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LOYOLA UNIVERSITY CHICAGO

WHO CARES? THE ROLE OF NURSING ASSISTANTS IN THE LABOR PROCESS
OF HOSPITAL NURSING

A DISSERTATION SUBMITTED TO
THE FACULTY OF THE GRADUATE SCHOOL
IN CANDIDACY FOR THE DEGREE OF
DOCTOR OF PHILOSOPHY

PROGRAM IN SOCIOLOGY

BY

GRACE EILEEN SCRIMGEOUR

CHICAGO, ILLINOIS

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Embarking on this research has taught me that it really does take a village to raise a PhD. I would like to thank my advisor, Professor Anne Figert and my mentor, Professor Judith Wittner. They have encouraged and supported me through the long and sometimes difficult journey including two serious illnesses. Thanks are also due to Professor Jennifer Parks, who served on my committee and offered some very helpful interdisciplinary insights. I must also thank Loyola University Chicago, who have awarded me several scholarships over the years, including the Pre-Doctoral Teaching Fellowship and the Advanced Doctoral Fellowship. As an overseas student, I was unable to access educational loans, so support from Loyola has been particularly important.

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I would also like to thank the CNAs who agreed to be interviewed. I found out that CNAs have busy and full lives, and giving up their time to talk to me was generous

on their part. Their openness is responsible for the rich data I was able to collect, and I look forward to reporting my findings back to them.

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To my aunt, Madeleine O'Brien, and my partner, Mustafa Hussein

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ABSTRACT

This research, using the feminist methodology of “reading up the power structure,” is the first study of hospital-based Certified Nursing Assistants (CNAs). Through interviews with 21 CNAs in a large, independent, urban hospital in the Midwest, the study examines how two major institutions have impacted the labor process of CNAs and the division of labor between CNAs and RNs. These include historical changes in nurses’ priorities in pursuing professional status, and the reconfiguration of healthcare provision in the United States. The removal of LPNs from hospital nursing creates a clear division of labor between RNs and auxiliaries since, unlike LPNs, CNAs are unable to substitute for RNs. CNAs have been cross-trained to replace clerical and technical workers, but this does not impinge on the labor process of RNs.

CNAs perceive good care as incorporating both instrumental and affective elements, in opposition to detached, “professional” healthcare, and they take a holistic view of patient welfare that corresponds with Foucault’s “pastoral power.” When dealing with difficult patients, CNAs choose alternate strategies; “killing them with kindness,” or “being professional” (withholding affective care.)

There is a limited career ladder for CNAs, but many create their own dynamic ladder by combining work and study, gaining higher education incrementally over many years. Hospitals support this in formal and informal ways that are not available in other healthcare settings, such as nursing homes.

CHAPTER ONE

INTRODUCTION

The first thing I noticed when visiting the hospital units at Northside Hospital is that the different kinds of nursing workers are clearly identifiable because they wear different colored scrubs, signifying the hierarchy of hospital nursing care. CNAs wear navy blue scrubs, while RNs are dressed in royal blue. Unit Assistants (who are also CNAs, but work as receptionists and clerical workers) wear burgundy (field notes 11/26/12-12/10/12). In this way, the status of workers is clearly defined to other workers, and, presumably, to patients as they become familiar with the system.

My interest in nursing assistants in hospital settings was stimulated by my own experience as a cancer patient in two different hospitals (not at Northside) over the summer of 2005. While hospitals in the United Kingdom (my home country) are still organized around open wards, in the United States most patients are in private rooms and, apart from visitors, most human contact occurs while being examined, having vital signs taken, dressings changed, and similar. Among the constant ins-and-outs of staff, the people I saw most frequently were nursing assistants, most of whom were African American women who I estimated to be between 25 and 35 years of age. Every morning the CNA assigned to me for the shift would come into my room, open the blinds, wish me good morning, write the date, her (it was usually a her) name, and that of my supervising nurse on a whiteboard next to my bed, occasionally adding a brief

personalizing message about the weather, or something religious. She changed the sheets and made my bed. She took my vital signs regularly, and emptied out the drains from my wounds. If I used the call-light to call for assistance, it was the CNA who acted as gatekeeper and decided if she could address my needs, or if the nurse should be called. I saw the nurse rarely, when medications were given or new fluids needed to be hung, or if dressings were changed. This surprised me. I knew that personal care in nursing homes was largely performed by nursing assistants, but assumed that in hospitals most of these tasks were still done by “qualified” nurses. I began to wonder who these CNAs were: In the highly hierarchical setting of a major teaching hospital they were obviously very near the bottom of the ladder. Their job seemed to have very little medical content, just the taking of vital signs, which was in any case somewhat mechanized. Where did they fit in? Did they have aspirations beyond this kind of care work? Was this a terminal career, or a stepping stone? This research addresses those questions.

This study examines the role of nursing assistants in hospital nursing through semi-structured confidential interviews with 21 certified nursing assistants (CNAs) at Northside Hospital, an acute care hospital in a large, Midwestern, urban metropolis. Northside is a not-for-profit, independent hospital; of all non-government community hospitals, only 38% are not part of an HMO (Health Forum LLC 2014). It is located in an ethnically-diverse part of the city where residents have moderate income levels.

As I discovered from personal experience, CNAs work in hospitals as part of a larger frontline nursing team that is supervised by registered nurses (RNs) and which may also include licensed practical nurses (LPNs). The separation of supervisory and technical aspects of nursing from the personal care of patients has meant the replacement of RNs

with assistants in the production of bedside care. In addition, the need for a flexible workforce to reduce costs, and the declining use of LPNs in hospitals has meant that CNAs are being cross-trained to fulfil a variety of roles within the unit in addition to their personal care tasks. Despite this, CNAs have not been studied in a hospital setting, and are almost invisible in the research literature.

CNAs are the staff seen most regularly by patients, and their unique position means that they frequently act as gatekeepers and conduits for information between patients and nurses. Their personal care of patients when most other staff members have a medical rationale for their attendance means that the CNA has become the humanizing face of the hospital, fulfilling the care role that nursing previously claimed as its special contribution. Their role within a complex technological, hierarchical and bureaucratic institution that is also a service industry makes them an interesting case study in the division of labor in the service sector, both in the United States and internationally.

The routes to the different credentials of the nursing team in hospitals are quite complex, and are discussed below.

Credentialing and Training in Hospital Nursing Teams

There are three levels of credentialed nursing staff that work in frontline care in hospitals, with registered nurses (RNs) being responsible for the supervision of auxiliary nurses, both CNAs and licensed practical nurses (LPNs) at the unit level. However, there are different routes for obtaining the RN certification, and this appears to be leading to a two-tier system for RNs, with nursing Magnet Status¹ in hospitals being tied to the

¹ The Magnet Recognition Program is a designation awarded by the American Nurses Credentialing Center using criteria designed to measure nursing quality in terms of patient outcomes, nurses' job satisfaction and nurses' involvement in decision making concerning patient care delivery (The Truth about Nursing 2012).

proportion of baccalaureate RNs among the staff. In addition, LPNs are no longer seen in great numbers in hospitals; since the advent of large healthcare corporations, auxiliaries have been shifted to other healthcare settings, particularly nursing care homes. The routes to credentialing for different members of the hospital nursing team are as follows:

Registered Nurse (RN)

Registered Nurses are qualified to perform all nursing tasks, and to supervise other grades of nursing staff. To become licensed, nurses must graduate from an approved nursing program and pass the National Council Licensure Examination.

There are three approved nursing qualifications that lead to RN certification. The oldest qualification is the Diploma, which is offered by hospital-based nursing schools, usually over three years. This route to the RN credential has been declining dramatically for several decades, and less than 4% of new RNs (2008 figures) graduate from diploma programs (National League for Nursing 2009a). However, due to the aging nursing population, one fifth of currently-registered nurses have the diploma (U.S. Department of Health and Human Services, Health Resources and Services Administration 2010).

The Bachelor of Science in Nursing (BSN) is a four-year degree program offered at universities. Bachelor degree programs have been available for almost a century, although for several decades most RNs took the Diploma route. While its popularity is slowly increasing, it still only represents around 36% of new RNs, and around one third of current RNs hold the baccalaureate (National League for Nursing 2009b; U.S. Department of Health and Human Services, Health Resources and Services Administration 2010). However, there is a strong push from nursing leaders and organizations to make this the standard entry-level qualification for RNs (American

Association of Colleges of Nursing 2012; Institute of Medicine 2011), and to encourage nurses working in acute care to upgrade their training, particularly as research suggests a link between the proportion of nurses holding lower qualifications of nurses and higher mortality rates in hospitals (Aiken et al.. 2003).

The most popular route to basic RN certification is the Associate of Science in Nursing (ASN) degree, also known as an Associate Degree in Nursing (ADN). This is a two-year course that was introduced in the 1960s. It is offered mainly in community colleges and for-profit colleges (Bureau of Labor Statistics 2012a). Fifty eight percent of new nurses (2008 figures) graduate with an associates' degree (National League for Nursing 2009c) with 45% of currently registered nurses holding that qualification (U.S. Department of Health and Human Services, Health Resources and Services Administration 2010). However, a significant proportion of these take conversion courses or return to study to complete their baccalaureate in nursing or a closely related program; around one third of BSN holders started with a diploma or associate's degree (U.S. Department of Health and Human Services, Health Resources and Services Administration 2010).

While the BSN is considered the gold standard of nursing education, all RNs are known as 'graduate nurses' in the nursing literature, to distinguish them from 'auxiliary nurses', who include both nursing assistants and LPNs/LVNs

Certified Nursing Assistant (CNA)

State certification and registration is a federal requirement for nursing aides in most settings, including nursing homes and home health care (Bureau of Labor Statistics 2012a). Certification is not a federal requirement for nursing assistants in hospitals,

because of the high ratio of RNs to aides in hospitals compared to other settings; RNs make up 30% of total employees in hospitals and aides only 8%, compared with nursing homes, where staffing includes 20% nurses and 38% aides (Scanlon 2001). However, it is a state requirement in some states, and frequently an institutional requirement in hospitals.

Requirements for certification include an eighth grade education and, like all health care workers, they must pass a criminal background check (Illinois Department of Public Health N.d.b). Disqualifying offenses include all violent crime and offenses against children; theft; tampering with food, drugs or cosmetics; neglect, abuse, or exploitation, of elderly or disabled people; forgery; arson; criminal trespass; weapons convictions; credit card convictions; and any drug convictions beyond simple possession (225 ILCS 46/ Health Care Worker Background Check Act). In addition, applicants, must complete an approved training program of at least 75 hours, and pass a written and oral competency test (Illinois Department of Public Health N.d.a; Scanlon 2001). Training courses can take as little as five weeks to complete, and cost around \$1000. There are around 200 approved training programs in Illinois, and locations include staffing agencies, work sites, high schools, community colleges, private colleges and training centers (Illinois Department of Public Health N.d.c). Other states, notably Oregon, have introduced a level 2 CNA certification in acute care, allowing CNAs to take on additional tasks such as dressing wounds (Oregon State Board of Nursing N.d.), which may be a way of replacing the loss of LPNs in hospitals. However, the level 2 certification is not available in the Midwest.

Licensed Practical Nurse (LPN)

The LPN certification (Licensed vocational nurse, LVN, in California and Texas) was introduced in the 1950s, and requires a one year approved practical nursing program and passing both a national and a state licensing exam. Training is offered at community colleges, vocational schools and for-profit colleges, as well as some high schools. Many LPN programs require or prefer students to pass the CNA certification before moving on to the LPN curriculum, or offer the CNA training as the first part of LPN training. LPNs are qualified to do more medical procedures than assistants, including dressing changes, catheterization and drawing blood, and, in some states, administering medications and setting up IV lines. However, LPNs work under the supervision of doctors or RNs, so are considered auxiliary nurses (Bureau of Labor Statistics 2012b).

The use of LPNs in acute hospitals has been declining over the last 20 years, and they are now only a small part of the nursing team. In 1984, over half of all LPNs worked in hospitals, but by 2001, this had declined to a third, with a fall of 5% between 1993 and 1994 alone (Seago et al. 2004). However, LPNs were retained in larger numbers in for-profit and in government hospitals where cost-cutting was prioritized, since LPNs could substitute for RNs (Seago et al. 2004). There are also regional differences, with higher proportions of LPNs in the South and the lowest in the Northeast (Seago et al.. 2004). At the current time, LPNs comprise only 7% of the nursing team in acute hospitals (Bureau of Labor Statistics 2014a).

Characteristics of Nursing Assistants

There are over 1.5 million nursing assistants employed in the United States, with 42% working in nursing care facilities and 26% in general hospitals (Bureau of Labor

Statistics 2014a). Workforce predictions suggest an increase of 14% in the number of nursing assistants working in hospitals by 2022 (Bureau of Labor Statistics 2013).

Nursing assistants are known by a variety of titles in different settings, including nurses' aides, home health aides, orderlies (usually men), and patient care technicians (who may have additional training). They work in hospitals, in nursing and care homes, and in home settings. They provide hands-on personal care for patients under the supervision of nurses, including help with washing, dressing and eating, making beds, tidying rooms, answering calls and delivering messages. They are also frequently responsible for the routine vital signs measurements; temperature, blood-pressure, pulse and respiration rate. In these days of increased Taylorization of hospital work nursing assistants are the front-line of patient care (Bureau of Labor Statistics 2014b).

Around one fifth of aides are single parents, which is comparable to other service workers but almost twice that of workers in general. Forty-five percent have children under 18, which again is higher than the general workforce (Scanlon 2001). There is evidence to suggest that the changes in welfare introduced in 1996 (the Personal Responsibility and Work Opportunity Reconciliation Act) may have encouraged former welfare recipients into nursing assisting and other low-paid healthcare jobs (Solomon 2008). A study of the effects of PRWORA in Illinois² has shown that by 2003 the healthcare support sector (including CNAs) showed the greatest increase in the number of welfare-leavers employed, rising from 6.1% in 2000 to 10.8% in 2003 (Lewis, Collins and Anderson 2005). It was also among the better options for pay and benefits, with a

² The Illinois Families Study

mean hourly wage of \$9.71 in 2003, and with 41.1% of the workers receiving employer health benefits (Lewis et al. 2005).

Healthcare support also had the lowest level of job churning and the highest retention rate, with almost one quarter of those who were working from 2001-2003 staying in the industry, compared to 10% overall in the study (Lewis et al. 2005). A large study of CNAs in nursing homes showed that 56.7% had received public assistance at some time, with almost one quarter having received TANF (Centers for Disease Control 2008; Squillace et al. 2007). Nursing aides in general are twice as likely as average workers to be receiving Food Stamps and Medicaid, although hospitals offer better pay and benefits than other healthcare settings meaning that aides in hospitals are significantly less likely to be in poverty (Scanlon 2001; Yamada 2002).

It is striking that while aides in hospitals are more heavily supervised than CNAs working in other settings, they are at the top of the nursing aide hierarchy in terms of pay, benefits, job security and educational level (Yamada 2002). Seventy percent of hospital aides are under 44 (younger than in other settings), and almost half have at least some college education (compared to less than 30% of aides in nursing homes) (Yamada 2002). However, they are some of the lowest paid workers in hospitals, earning barely more than the lowest rank of catering and housekeeping staff. With a median hourly wage of \$13.53 and mean annual income of \$28,150, they earn around 63% of the national per capita income (Bureau of Labor Statistics 2014b; Scanlon 2001; Yamada 2002). Although wages for hospital aides dropped in real terms during the 1990s, they continue to be substantially higher than for aides in other settings; median hourly wages for CNAs in hospitals are 13% higher than in nursing homes (Bureau of Labor Statistics 2014a;

Yamada 2002). Two thirds of aides in hospitals work full-time and year-round (Scanlon 2001; Yamada 2001)

The job offers few possibilities for advancement, except with considerable additional training. Some people work as CNAs while embarking on nursing or premed education programs. In fact, many nursing programs and medical schools strongly prefer applicants with some healthcare experience, and working as a CNA is a way to gain that experience (The Princeton Review 2014). While there may be the expectation that good employers will pay for advanced training, in practice this appears to be uncommon, and many CNAs find it difficult to further their education due to family responsibilities and financial hardship (Bullock and Waugh 2004). Nevertheless, nursing assisting offers more than most jobs open to women with limited education; they are more likely to receive regular hours, medical benefits and paid vacations that many low-waged workers (Bullock and Waugh 2004).

Race and Intersectionality

Many occupations in healthcare are highly segregated by gender and by race-ethnicity. While nursing and nursing assisting are female occupations, physicians and surgeons are predominantly male (although this is changing). The proportion of male RNs has increased from around 3% in 1980 to 10% in 2011), with a similar pattern for LPNs (Landivar 2013). Currently, 30% of active physicians are women, although they are at parity or dominate in gynecology, pediatric and geriatric specialties. They make up around 15% of general surgeons, but have much lower representation in other surgical specialties (American Association of Medical Colleges 2012).

Women and people of color are highly overrepresented among nursing aides, as

they are in most low-waged service occupations. In hospitals, one fifth of nursing aides are male, which is much higher than in nursing homes. One third of nursing aides are black and 22% are Hispanic (Scanlon 2001; Yamada 2002). In states with great ethnic diversity a much larger proportion of CNAs are immigrants: For example, in California almost half CNAs are not native English speakers (Bullock and Waugh 2004).

A study of occupational segregation in healthcare (Queneau 2006) compared the proportion of women working as nursing aides to their representation in the general workforce. The Queneau study showed that in 2003, women were twice as likely to be employed as nursing aides than their numbers in the working population would suggest, and this proportion has barely changed in twenty years. The 2003 ratios for RNs and LPNs were even higher. Clearly, nursing occupations are heavily dominated by women, not only in the sense that women make up the majority of workers, but also in the fact that women are more likely to be in these occupations than in other kinds of work.

Occupational segregation by gender and race-ethnicity has negative impacts on average pay for women and minorities, because jobs which are predominantly held by women and minorities have lower pay than jobs requiring similar education and skill levels that are male-dominated (Acker 1990; Queneau 2006; Reskin 1988). Between 12% and 37% of the gender pay gap in the United States is explained by occupational segregation, and workers in predominantly black occupations earn 18% less per hour than those in comparable white occupations (Queneau 2006).

Women of color, particularly black women are highly overrepresented in nursing assisting and underrepresented in graduate nursing, particularly in the upper levels of the profession. In 2003 blacks were overrepresented as nursing aides by a factor of 3

compared with their presence in the population, and by a factor of 2 as LPNs. Hispanics are represented as nursing assistants at a rate comparable to their representation in the labor force, but are severely underrepresented among qualified nurses; they are underrepresented by a factor of 4 as RNs and a factor of 2.5 as LPNs (Queneau 2006).

While occupational segregation has declined over the last 30 years, this process has slowed down, particularly with regard to predominantly female and non-white occupations. This is explained by two major factors; first, while these jobs continue to pay less than equivalent white and male jobs there is little incentive for white people and men to move into them (Reskin 1988; Williams 1995). Second, occupational segregation reinforces gender and racial stereotypes, again making it less likely that dominant group members will choose to do them (Queneau 2006; Williams 1995). The negative stereotyping of occupations also limits the opportunities for career advancement of those employed in them (Queneau 2006). Both nursing and nursing assisting draw on symbolic images of women, including 'respectable' womanhood (drawing on Victorian ideals of white, middle-class femininity) (Malka, 2007) and controlling images of black women, particularly the Mammy and the Matriarch (Barbee, 1993; Collins, 1990). This has affected both the route to professionalization and status in nursing, and the discrimination against nurses of color.

In the era before the World War II, most nursing schools and hospitals were segregated or had quotas for black nurses, and black nursing students were expected to perform heavy domestic work alongside nursing care. The token black nurses who were employed in 'white' hospitals were paid 60%-80% of the wages of white nurses (Hine 1989). Even black hospitals and nursing schools were often under the direction of white

nursing leaders and academic supervisors into the 1940s, since few black nurses had the necessary academic qualifications to take on these roles (Hine 1989). The Second World War led to greater opportunities; the Bolton Bill in 1943 established the U.S. Cadet Nurse Corps under federal control and included an anti-discrimination clause. Funding was available for student fees and stipends in return for a pledge to serve in the services or in civilian posts until 6 months after the war ended. This led to the expansion of black nursing schools, and the desegregation of many white schools (Hine 1989). Military wards were still segregated, and black military nurses were denied some of the privileges of their officer status, but work opportunities opened up. After the war, the long-term exclusion of black RNs from the American Nursing Association, the primary professional nursing organization, came to an end (Hine 1989).

In 1951, only 3% of nursing students were black, but the introduction of programs in community colleges leading to LPN certification and, in the 1960s, to RN certification made nursing accessible to a greater number of poor and minority women (Bullough and Bullough 1978; Hine 1989). By 1975, 8% of RN students and 15% of LPN students were black, with the greatest proportions in college programs rather than nursing schools (Bullough and Bullough 1978). While in this period, urban hospitals increasingly relied on the services of black nurses, they still faced both individual and structural racism. While the status of nursing had increased greatly, black nurses found it more difficult to shed the image of domestic servant (Barbee 1993; Collins, 1990; Hine 1989). Even institutions that trained black nurses rarely promoted them to leadership positions, preferring white nurses or black male physicians (Hine 1989).

The role of black nursing aides in earlier periods of nursing is even more difficult

to trace than for white nursing aides, not least because black workers who filled those roles were often not even called ‘aides’ before the 1950s, but had the title ‘maids’, to distinguish them from white aides, and as a reinforcement of their traditional role as domestic servants (Glenn 1992; Hine 1989; Sacks 1988). Black women were much more highly represented in auxiliary nursing than as RNs and, particularly in the South, there was a pattern in many hospitals of all-white RNs supervising mainly black LPNs and aides (Malka 2007).

The changes in the ways hospitals were managed, including the combination of ‘industrial’ efficiency and the continuing paternalism of management, were felt most keenly in hospitals with a majority of black workers (Sacks 1988). The Civil Rights movement and a growth in union militancy in the period from the late fifties to the mid seventies led to a growth in hospital unionization, starting in the north and moving south (Sacks 1988). For example, in the fifties hospital services at Duke University Hospital were segregated, and black aides were defined as “nurse’s maids” and were often treated as personal servants by head nurses (Sacks 1988). They suffered from a lack of clear job definition and schedules, as well as the absence of job mobility and black supervisors (Sacks 1988). The work of the black nurse’s maids often overlapped with that of the white nurse aides, but there was a color bar that prevented even those that were qualified from being promoted to aides (Sacks 1988).

In the 1960s a mass effort at unionizing at Duke led to demands both for improved wages and more opportunities for black workers, and in 1968, industrial action by the mainly-black, lowest paid workers led to an opening up of jobs (Sacks 1988). However, while black workers were now able to gain employment in practical nursing

and technical jobs, nursing staff were still split along racial lines with black LPNs and white RNs (Sacks 1988). Although healthcare occupations are no longer formally segregated, blacks and other minorities are still overrepresented in the lowest levels of nursing care, meaning that there is stratification based on race and class with CNAs, frequently minorities, being responsible for the “dirty work” and emotional care, supervised by white RNs (Bullock and Waugh 2004; Duffy 2007; Glenn 1992; Lopez 2006; Misra 2003; Rakovski and Price-Glynn 2010).

As in other occupations, discussion of race and racism in nursing has been glossed over by a discourse of difference and cultural diversity which ignores structural issues in favor of an approach that reduces racism to cultural bias resulting from ignorance, something which can be overcome by education. Many nurses hold to the idea of color-blindness, leading to a denial that racism exists in nursing. The ideology of nursing, particularly the individual orientation towards providing care, leads to a preference for avoiding personal and organizational conflict, meaning that structural issues are often left unacknowledged. This is easier when nurses are homogenous in terms of race, class and gender (Barbee 1993). While issues of racism in nursing have been marginalized there has been a recent tendency to treat men in nursing as a minority in the tradition of affirmative action, without a real analysis of gender, class and race. This overlooks the advantages that (white) men encounter in traditionally female occupations (Hoff, 1994; Williams 1995). However, research suggests that white, male CNAs do not ride the glass escalator, unlike white, male RNs (Price-Glynn and Rakovski 2012). This may be because there is no escalator for CNAs.

Another important part of the intersectionality discussion is that of class.

Obtaining state certification as a nursing assistant requires only a low investment in education, time and money, so is easily accessible to working class women and men of all races and ethnicities; within a few weeks one can be working within a nursing home or hospital. This may be the first rung in a career ladder into other healthcare occupations, despite the additional training and credentialing required. Working within an acute hospital provides an opportunity to observe and work with a great number of other healthcare occupations, and the flexibility of a shift system makes it easier to combine work and study, particularly if the workplace provides benefits in the form of tuition reimbursement. While the path to higher credentialing may be slow and incremental, it does provide options for people who do not have the luxury of taking several years out of their working life to devote to further study.

Research Questions

I used a modified grounded theory methodology in my study, which I discuss in more detail in chapter 2. This means that, unlike deductive methodologies, I did not start with a series of hypotheses to be tested, although I did develop some preliminary research questions from the literature review. After the first phase of interviewing, I developed and modified my questions to reflect and explore the initial themes that emerged inductively from those early interviews, and used the revised questions in the later interviews.

My first question concerned the role of nursing assistants within the broader changes in hospitals, particularly in the rationalization of caring work. ‘Caring’ has been such a paradigmatic aspect of the role and identity of nurses, and I wanted to see if this aspect had been displaced onto nursing assistants as nursing has professionalized,

improved in status and become more technical and supervisory. I also wanted to find out how nursing assistants perceived their role as caregivers.

Second, I wanted to examine how nursing assistants saw themselves within the hierarchy of hospital life, including whether they perceived that their work was valued by other staff, and that their assessment and observations about patients were accepted and acted on. I was interested in how nursing assistants negotiated issues of race, class and gender in the workplace, and whether these factors helped them to construct a work and personal identity.

Finally, I was interested in the career paths of CNAs, including how they decided to enter the occupation, and whether they saw this as a terminal career, a temporary occupation or a stepping stone to higher-status careers in healthcare, while accepting that different factors would affect individual trajectories.

Rationale

Nursing assistants have not been studied before, at least in a hospital setting. I have been able to find no sociological or related research specific to hospital nursing assistants and little on CNAs in general. What work there is focuses on those employed in nursing homes (Diamond 1992) and much of this is concerned with training, standards and staff retention (Bullock and Waugh 2004; Duffy 2005; Lopez 2006; Rakovski and Price-Glynn 2010; Scanlon 2001; Squillace et al. 2007; Yamada 2002). There is, however, an extensive literature on hospital nursing, and by looking between the cracks of that work it has been possible to develop some hypotheses about the emergence and changing importance of nursing aides. Nursing assistants appear mainly in discussions concerning the nursing labor process, in literature that focuses on the activities and

interests of nurses (Brannon 1990; 1994a; 1994b; 1996; Bullough and Bullough, 1978; Chambliss 1996).

Nursing assistants are an expanding and poorly understood workforce, particularly in hospital settings. They are part of the low-paid, largely female, service sector, a demographic which is growing in the United States. However, they differ from this group in that they generally have recognized training and certification that is transferable between jobs. They also have a different status from cleaners, fast food workers and similar because of their association with nursing and medical work, even if they earn little more. In fact it can be argued that they work in the gaps left by the more highly-skilled workforce, doing those jobs which used to be part of bedside nursing care, but which it is now considered “inefficient” for nurses to do.

This study addresses and contributes to two main literatures in the study of work and occupations; first, labor process and the division of labor in service occupations and second, that of caring occupations, including discussion of emotion work and emotional labor.

The role of nursing aides within a complex technological, hierarchical and bureaucratic institution makes them an interesting case study in the division of labor in the service sector (Brannon 1990; 1994a; 1994b; 1996; Braverman 1974; Strauss 1997). The division of labor on the frontline of hospital nursing care has been structured by a set of larger institutional changes and priorities. In particular, changes in the business of healthcare, where the rapid growth of profit-making diversified healthcare corporations meant that auxiliaries were redeployed from hospitals to affiliated services, for example nursing homes and outpatient clinics (Brannon 1994b; Sacks 1988). Another institutional

factor that has at various times supported or challenged corporate priorities is the professionalization project of nursing leaders. They have used a variety of strategies to raise the professional status of nursing, including an emphasis on the technical and supervisory roles of frontline nurse, where staff nurses gain status as team leaders managing auxiliaries (Reverby 1979). More recent developments have seen the introduction of “lean service” ideas which have included the breaking down of work jurisdictions through the cross-training of workers (Brannon, 1996; Nelson-Peterson and Leppa 2007; Spear 2005; Viswanathan and Salmon 2000).

The changing division of labor also has international relevance, as issues concerning the use of nursing assistants alongside graduate nurses, role drift, caring as a core practice of nursing and similar are being debated in many different countries (BBC News 1998; Benoit and Heitlinger 1998; Castledine 2004; Corbin 2008; Dahle 2003; Davies 1982; Daykin and Clarke 2000; Edwards 1997; Lee-Treweek 1997; Maben 2008; McKenna, Thompson, and Watson 2007; Thomas 1994).

The work of CNAs is organized around the personal care of patients, and this study contributes to the continuing debate over care work. This literature incorporates both categorizing differing elements of care and the question of emotional labor. In looking at nursing assistants and nursing work in general it is necessary to distinguish between reproductive care, the physical “dirty work” that is commonly undertaken by nursing assistants; nurturing or emotional care, which is part of their work, but which may also be performed by workers higher in the hierarchy (Duffy 2005; Lopez 2006; Rakovski and Price-Glynn 2010) and emotional labor, which is the requirement to display organizationally sanctioned emotions on the job in order to elicit particular

emotions from the patient (Bullock and Waugh 2004; Hochschild 1983; Steinberg and Figart 1999a). This study addresses these distinctions and their importance to workers at the front line of nursing care.

This study also contributes to the literature on intersectionality, since various combinations of race, ethnicity, class and gender are salient in the lives of nursing aides, and in their relations to other workers in hospitals. In particular, the hierarchical division of nursing care reflects stratification based on race and class, (Bullock and Waugh 2004; Collins 1990; Duffy 2005; Glenn 1992; Lopez 2006; Misra 2003; Rakovski and Price-Glynn 2010), but not on gender, since the great majority of both nurses and nursing assistants are women.

Brief Literature Review and Structure of the Dissertation

A detailed review of the relevant literature is contained within the relevant chapters, but there are three themes that have emerged in the study, and which correspond to the three chapters dealing with the findings from the research. These themes are briefly discussed below.

The Changing Division of Labor in Hospitals and Nursing Care

The social organization of hospitals has become increasingly specialized and technical (Strauss et al.. 1997). Organizational rationalization and efficiency have become watchwords in response to increasing pressures from insurance companies to reduce costs through policies like “managed care” (Head 2003). One response has been to reduce the proportion of nurses and increase that of auxiliaries, particularly in nursing homes and outpatient facilities (Brannon 1990; 1994a; 1994b; 1996; Queneau, 2006), This draws on 20th century principles of scientific management (Taylor 1916), with the

deskilling of areas of the labor process through establishing routines and removing worker autonomy (Braverman 1974). Recent decades have seen the extension of practices that were formerly established in manufacturing into the service arena (Ritzer 1996), including into hospitals. In the case of nursing care, this has led to two, sometimes contradictory strategies. The first approach is the Taylorist separation of the supervisory and technical aspects of nursing and the ‘touch’ work and comfort tasks for patients, with nursing aides taking on the latter work. The second, more recent, approach has been the introduction of aspects of “lean service” principles developed from Japanese manufacturing practices (Viswanathan and Salmon 2000; Spear 2005; Nelson-Peterson and Leppa 2007). These can be seen as contradictory because while both approaches derive from a detailed analysis of work processes and improvements to efficiency from making changes to them, they come to different conclusions with regard to implementation. The older scientific management system aims to decrease the flexibility of individual workers, while the Kaizen (continuous improvement) system encourages efficiency through flexibility and breaking down work jurisdictions.

In the case of nursing care, nurses and auxiliaries have been subject to changing divisions of labor which are influenced at different periods by both of these approaches to the labor process. While nurses have worked to be accepted as full healthcare professionals, unlike medical knowledge, where practice is assumed to be theoretically-based, nursing knowledge is assumed to be practice-based, with theory being generated inductively. This may be a false opposition, based in gendered concepts of knowledge and expertise, but it results in hierarchies of knowledge regimes. Because they have worked alongside auxiliaries, and have been vulnerable to substitution, RNs have been

unable to fully establish a core of specific knowledge and expertise and achieve social closure and full acceptance as professionals under any of the different labor processes that have operated in hospitals (Dahle 2003).

In nursing homes, where the majority of workers are CNAs, care work tasks are regarded as simple, and CNAs are seen as competent to carry out these tasks, while in hospitals, nurses have argued that the same tasks are complex and theoretically demanding and have at various times tried to take them back from auxiliaries (Brannon 1990; 1994a; 1994b; Dahle 2003). There is a medical rationale for professional bedside nursing; nurses claim that their expertise in observing and interpreting patients' health and well-being while conducting intimate care tasks is necessary for good patient care. This gap is often bridged bureaucratically, particularly in nursing homes, where the work is ruled by checkboxes of tasks done, and rigid categories concerning the "state" of the patient, for example amount of food eaten (Diamond 1992; Latour and Woolgar 1986; Taylor 1916). A paper trail has become the way to formally evaluate the patient's condition, so that someone who does not have a nursing qualification can chart the empirical changes that the charge nurse is responsible for evaluating, and that she is liable for if problems arise.

This can cause friction between CNAs and nurses, particularly when new nurses are working with experienced CNAs who take a pride in their work. Like the difficulties between inexperienced doctors and experienced nurses, CNAs can be resentful when directed by an inexperienced nurse, even if the nurse has the ultimate responsibility for patient care (Edwards 1997; McKenna et al. 2007). This division of labor has been a source of both pride and conflict for nurses, and the ambiguities and difficulties

surrounding it been at the heart of conflicts over the changing labor process. Chapter Three discusses in detail the labor process and the changing division of labor within hospitals, and findings on the labor process and the division of labor between CNAs and RNs at Northside Hospital.

Caring, Gender and Nursing Work

Both nursing and nursing assisting are overwhelmingly, in fact paradigmatically, female occupations. This has affected the development and status of those occupations, how they are viewed, and how they both construct and promote a particular kind of feminine identity. This is summed up in the axiom on the role of nurses in the medical system; “doctors cure, nurses care.” While more general theories of gendered work and gendered organizations are applicable to this study (Acker 1990; Williams 1995), the most relevant previous work is the extensive literature on caring and care work, and in particular emotion work and emotional labor.

Nursing assisting is part of a broader group of occupations classified as “care work,” which is itself a subdivision of service work, where workers are not only accountable to their employers, but also to clients or customers. Care work covers a range of jobs with different levels of status and credentialing. Caring was traditionally performed in the private sphere by women who provided care for their families. The commercialization of tasks formerly conducted in the private sphere (England, Budig and Folbre 2002; Hochschild 2003) means that the care giver is now commonly employed by an institution, and the patient (and their family) no longer have a major role in the evaluation of the appropriateness and delivery of care (Tronto 1993). Hospital care is produced in the public sphere, by organizations that fragment it into countable

components, and the relationship between caregiver and patient is now subservient to the assessments of a number of institutions that allocate, provide, monitor and pay for care, including hospitals, insurance companies, the state, and charities (England, Budig and Folbre 2002; Stone 2000; Tronto 1993). Those who need the most care are often least able to pay for it (the sick and the old) and they are frequently dependent on payment by third parties, including the state, insurance companies and family members (England, Budig and Folbre 2002). It is hard to measure the indirect, public, benefits of care work for example the benefits to employers and society of having a healthy workforce and citizenry. As a result, its social value is under-recognized, which may be one factor accounting for the low pay in care work (England 2005).

Care giving is underpaid even when compared to jobs involving similar levels of skill, education and sex composition (England 2005; England, Budig and Folbre 2002; England, and Folbre 1999; Kilbourne et al.. 1994; Steinberg 1999). It is not clear whether the pay penalty for caring jobs is because caring is devalued, or because it is usually done by *people* who are devalued; women, people of color and the working class (Cancian and Olicker 2000; England 2005; England, Budig and Folbre 2002; Misra 2003; Tronto 1993). There is a certain essentialist implication that dirty, less civilized people are more suitable for jobs dealing with natural bodily functions, so that “dirty” jobs further devalue those who are considered low status (Reskin 1988; Tronto 1993). Jobs that are within the caring nexus tend to increase their professional status by becoming distanced from physical care, and this has been one strategy used by professional nursing organizations to improve the professional status of RNs (Tronto 1993).

While nurses emphasize the difference in ethos between nursing and medicine

(“doctors cure, nurses care”) in practice their work is directed by doctors, and by the workplace administration. The concept of “caring” as part of nurses’ identity clashes with an organizational philosophy that devalues caring in favor of instrumental rationality. The role of the hospital nurse has three, often contradictory, elements. The nurse is expected to be a caring individual, a “professional” and a relatively subordinate member of a complex organization. Being “caring” is often at odds with being a “professional,” which requires a detached, objective demeanor. Being a “professional” is contradicted by being a subordinate, since one of the elements of professional status is autonomy in decision making (Abbott 1988, Chambliss 1996).

One way of raising the status of traditionally female occupations has been to increase and emphasize the technical component of such jobs, and to increase the overt responsibility levels, a strategy that has been pursued by nursing leaders. This has gender implications, since caring is seen as an essential female characteristic, rather than a skill, and hence undervalued in the world of work, both in terms of status and of remuneration. Lower-level jobs (which includes most jobs that are predominantly held by women) are defined as those with low levels of complexity and responsibility, and as low skill. Skill tends to be defined as technical or technological skill, characteristics that are coded as male (Acker 1990) and while nursing is an overwhelmingly female occupation, men who do enter the profession are clustered in particular settings like the emergency room, ICU or the operating room; all these areas are places where technology is more important than “caring” (Williams 1995). As they gave up the white dress and cap for scrubs or day clothes, these nurses also gave up some of the symbolism associated with nursing for dress that was more associated with physicians.

With the increase in the status of professional nursing, the bureaucratically undefinable (and thus, devalued) aspects of the job, the personal care elements, have been largely handed down to nursing assistants under the supervision of nurses. Since nursing assistants are prohibited from doing all but the most routine medical procedures, their interactions are more concerned with sentimental and comfort work. Almost everyone else the patient comes into contact with has a medical or technical reason for their interaction. While other workers are constructing the person in the hospital as a “patient” (Chambliss 1996; Strauss 1997), CNAs’ personal care allows them to add the human element, fulfilling the “tender, loving care” role that nursing previously claimed as its special contribution. This is the piece missing from the rationalization of the hospital environment.

Unlike in nursing homes, where relationships of care can be built up over years, the relationship between nursing assistants and patients in hospitals is fleeting, and subject to work assignments and work schedules. However, even though the short periods that most patients spend in hospital might be expected to militate against engagement of the emotional aspects of caring in that setting, it is clear that there is still an idea of emotional “caring” in the abstract among nursing assistants in hospitals, and that aspect is highly valued by CNAs. This is shown by the frequent reference to the family in similes of care, with many of my interviewees expressing that they aimed to give patients the kind of care they would want for their own family members.

One of the key debates over emotional labor is whether its effects on workers are positive or negative. Some research suggests that effects may be positive in jobs with a higher level of autonomy, while in other studies, it is argued that people who take jobs

requiring high levels of emotional labor may be self-selecting. However, some of this debate seems to confuse nurturing/emotion work, which is generally valued by care workers, with emotional labor, which may be more problematic (Bullock and Waugh 2004; Lopez 2006; Theodosius 2006). Unlike residential and nursing homes, where emotion work is commodified and is clearly emotional labor, the situation is more complex in hospitals, where the main “commodity” is not care, but medical treatment. While CNAs in hospitals clearly do a great deal of emotion work and emotion management, whether this constitutes emotional labor is less clear.

CNAs also invoked an apparently contradictory pair of sentiments; first, that there should be no VIP treatment and everyone was deserving of the same level of care, and second, that they tried to personalize the experience of patients by providing individual services based on their perceived needs. Previous studies have shown that in nursing homes CNAs see themselves as the real caregivers, although they hold the least institutional power (Bullock and Waugh 2004; Diamond 1992), and the findings of this study corroborate that. Nursing assistants’ revaluation of care creates a new social order, turning institutional hierarchy and priorities on their head (Bullock and Waugh 2004; Diamond 1992). I explore this, and other feelings about care, emotion work and emotional labor in Chapter Four.

Career Trajectories of CNAs

Whether there is a realistic and accessible career ladder from the occupation of nursing assistant in nursing homes is a question that is starting to be discussed in order to improve retention and recruitment (Scanlon, 2001). While nursing homes have a relatively flat hierarchy and a fairly limited range of occupations, hospitals are

hierarchical institutions with a much more complex division of labor, with occupations ranging from the least credentialed, for example, cleaning staff, to very highly credentialed professionals, for example, physicians. One of my research questions was whether this day-to-day contact with this wide range of occupations was a resource for CNAs which gave them ideas of where their career could go beyond their current position. Chapter Five discusses the career trajectory of CNAs at Northside Hospital, including past occupations, training and education, how they became CNAs and at their future aspirations for their career. Questions about how and why they became CNAs were particularly interesting with several themes emerging concerning either previous informal care experience within the family, or a contact with hospital CNAs through visiting family members who were patients. While the formal educational requirements for nursing assistants are very low, those that work in hospitals are more likely to have some college education than those in other settings. This was certainly true of many of my interviewees, some of whom were combining full or part-time work as a CNA with two or four year college, often, but not exclusively, in pursuit of careers in nursing or healthcare. This pursuit of higher education was often slow and incremental, but the flexibility of hospital work schedules made it possible for working-class students to reach towards their goals. For the younger CNAs in particular, this was not seen as a terminal career, but as a stepping stone to occupations with higher pay and status. One conclusion is that the accessibility of training and jobs for CNAs in hospital provide opportunities for working class people to combine work and study to produce a dynamic incremental route to social mobility.

Conclusions

In the concluding chapter I summarize the main findings of the study, and discuss their contributions to the literature on work and occupations, care work and emotional labor. In addition, I discuss the implications of the findings and the limitations of the research, before suggesting a number of avenues for further research that would build on this study, which is the first work examining hospital-based CNAs..

CHAPTER TWO

METHODS AND DATA

Getting access to health care sites is a problem, since it frequently requires negotiating two Institutional Review Boards (the university and the hospital), and meeting the requirements of the HIPPA regulations¹. In addition, while many hospitals are accustomed to having onsite research projects, these are generally concerned with medical issues and outcomes, rather than qualitative institutional studies. The latter may not be perceived as useful or valid, and may be seen as burdensome to the work of the hospital. In addition, I had no personal contacts in hospitals that might have eased my path in gaining access.

Research Strategy

Because of the issues described above, my research strategy was guided by pragmatism. Ideally I would have liked an observation component, where I shadowed nursing assistants on their regular duties. However, even if a research site had been willing to countenance this approach, the HIPPA regulations would have required obtaining signed consent from every individual patient who was part of the observation, and that would have been extremely obtrusive and time-consuming.

I also investigated the possibility of undertaking the CNA training course, and making contact with other nursing assistants in order to follow them in their future career.

¹ The Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects the privacy of individually identifiable health information

However, after making initial contact with some classes, I found that the institutions were not interested when I mentioned I wanted to take the course as a participant observer, and there were additional difficulties with my status as an overseas student in terms of fees and certification. Furthermore, since the majority of CNAs work in nursing homes, it would have been difficult to anticipate who would be working in a hospital in the future, and I would also be focusing on inexperienced CNAs. This method would have required considerably more time for data collection, which would have been problematic given my visa status.

The most practical method for data collection seemed to be to interview hospital-based CNAs about their daily routines by gaining access to a single hospital. This would have the advantage of removing differences between institutions that might affect the division of labor in hospitals. This would also provide a single access point from which to recruit participants. It would require permission from a hospital going through a second institutional review board (IRB) as well as the Loyola IRB. However, it would not require dealing with HIPPA regulations, since there would be no observations of patients, and could be achieved in a timely manner if access were granted.

Eligibility and Sampling

Eligibility for the study included any nursing assistants who were willing to participate, who were over 18, and who spoke and read English. I had planned to interview 30 nursing assistants, but was ultimately only able to recruit 21. Participants were recruited by visiting all hospital units that used CNAs during the handover periods, talking briefly about the research and collecting names and contact details, which I then followed up by telephone or email. I also left flyers and business cards with my details,

and some CNAs contacted me directly. I also discovered that some CNAs were encouraged to contact me by their Unit Managers.

I had hoped to sample participants to include subjects from at least 5 hospital units, and with a variety of demographic traits, for example, gender, race, ethnicity and age, including over-sampling for underrepresented groups (e.g., men). This was not intended to produce statistically significant data, but to provide enough variation so that significant themes, similarities and differences would emerge, providing a starting point for further investigations. In the event, I interviewed all participants who made and kept an appointment. However, these included people with a wide variety of demographic traits and from a majority of units within the hospital.

Incentives and Human Subject Concerns

Each interview participant was offered a gift card for a national department store in the amount of \$20 in recognition of their participation and their time. Using a store-based gift card avoided the heavy charges that more generic gift cards incurred, which can amount to 25% of the face value. The card was given after completion of the consent form at the beginning of the interview and participants were informed that they could keep it even if they terminated the interview early or chose not to answer some questions. In the event, none of the participants terminated the interview and two participants refused the gift card, preferring to conduct the interview without compensation. Both of these were childless, and in college, and spoke about wanting to help me as a fellow student in my research.

Participation in this study posed no more risk to participants than they would encounter in everyday life. Psychological effects seemed to be positive, given that

interviews were voluntary. Participants found it beneficial to talk about their lives and be listened to, particularly since nursing assisting is often seen as a low status occupation. Several participants expressed appreciation that someone was studying their work, apparently seeing it as a form of external validation. Participants were questioned about their employment, so confidentiality and anonymity was particularly important to allow them to make remarks that might be critical of the institution or other employees.

Methodology

The study was conducted using a modified grounded theory approach. While true grounded theory aims to go into research without preconceptions, and builds theory inductively during research (Charmaz 2006; Strauss and Corbin 1990), I chose to use a method of semi-structured interviews, with an initial schedule of questions based on my review of literatures that seemed relevant and on my research questions. These questions were not developed as hypotheses, but were merely lines of inquiry. This approach allowed my interviewees opportunities to tell their story in their own way by expanding on themes that seemed important to them and by including some open-ended questions. After the first seven interviews I made some changes to the interview schedule, removing some questions that were clearly not relevant to my interviewees (e.g., a question about unionization and formal networking) and adding questions that explored emerging themes, including the concept of “making patients comfortable.” By keeping an open mind, I was able to minimize the preconceptions that I took with me into the research, and build my conclusions inductively from the data, rather than using a deductive methodology which sets up hypotheses and uses a research strategy to test them (Letherby 2003). The inductive process was aided by the fact that there was so little

previous work on CNAs, and that most of this was policy-oriented rather than theoretically rigorous.

This is a study of women in a predominantly and paradigmatically female occupation which is also low status. It seemed appropriate to be guided by principles of feminist methodology, particularly in starting with the lives and concerns of the CNAs themselves (DeVault 1996; Harding 2006; Letherby 2003; Smith 1987). I came to the research as a middle-class, white, highly educated woman from the United Kingdom, and the subjects of my research are working class and, frequently, women of color in the United States. However, I have considerable experience as a community worker and training and experience in participatory research techniques (Chambers 1997; DeVault 1996). This has made me particularly aware of power imbalances in research, the importance of localized and particular knowledge and of allowing subjects to “tell their stories” freely.

In fact, my outsider status as a non-American may have been helpful: I found that a certain outsider “naivety,” along with acknowledging subjects’ expertise in their own lives, helped me to overcome some of the racial and power dynamics inherent in the interview interaction (Stanley and Wise 1993). My lack of knowledge of hospital procedure and jargon meant that I necessarily had to ask follow-up questions to understand the procedures and processes of the everyday work of the interviewees, emphasizing their expertise. However, I have been mindful of the need to acknowledge my own biases, particularly when it comes to the interpretation of data. I am planning to discuss my conclusions with the subjects of my research, as a “check back” that they consider these conclusions meaningful (Smith 1987).

I used the perspective of feminist standpoint theory in problematizing the local and particular experiences of a group of (mainly) women with minimal power and authority. By “reading up the power structure” (Mohanty 1984; 2003) I was able to examine how power structures within the hospital and within the larger institutions and practices of health care organizations, organize the daily life of CNAs. In particular, I looked at how these power structures connected CNAs to patients and other workers at all levels, but particularly RNs, through systematic interactions (DeVault 1996; Harding 1991; Mohanty 1984; 2003; Smith 1987). I was also able to examine how CNAs perceive their role within the larger structure of the hospital, and how they both contest and accept their position within the nursing hierarchy. As Acker (1990) has observed, two people at different levels of a job hierarchy cannot both take credit for the same work. Since the RN is responsible for the work performed by the CNA, the work of the CNA is frequently rendered invisible in the bureaucracy of the hospital. I interviewed only CNAs, and not the RNs that they interact with in their jobs, so I was able to gain an understanding of the CNAs’ perception of the relationship, and of the division of labor at the unit level which is, of course, a partial picture. However, considering the extensive literature on professional nursing, and the exclusion of the voice of CNAs in that literature, there are sound methodological reasons for focusing only on them in this study.

Access to the Site

Access to hospitals as research sites can be notoriously difficult, with many sociologists reporting that administrators at several hospitals refused permission to study before they were able to find a site (Chambliss, 1996). As an alternative to “top-down” access, Chambliss (1996) recommends an approach called “side-in” access. This involves

making informal contact with lower-level people in the organization, for example, nurses, and discussing research interest in a social setting. These initial contacts could give the researcher further contacts, eventually leading to contact with administrators and an invitation to visit and observe the hospital. At this stage, a formal research proposal could be presented, and permission was invariably granted. As Chambliss has written:

“Essentially, I never request access until I already know they’ll say yes” (1996:191).

This seemed like a promising approach, since it is much easier for an administrator to say “no” to any requests for research access by non-medical researchers, particularly if the researcher is unknown to the administrator. However, it would also be time-consuming, and even the initial contacts would be difficult, since the researcher had no existing contacts in the field. In this case it seemed easier to try the “top-down” approach, at least in trying to gain access, and to look for alternatives if this did not work.

In the early stages of developing the research topic I approached a suburban hospital that was not a research institution on the grounds that it would be easier to navigate only one institutional review board. However, they were concerned with having hospital management of the project. It would also have been difficult for me to travel there regularly, since I do not drive and public transportation to the site was poor.

When the research proposal was more developed I decided to focus on hospitals that were easily accessible to me by public transportation. My only other criterion was that it was an acute care hospital. Towards the end of July, 2012 I made a list of 9 suitable hospitals and researched them to try to find the names of their Director of Nursing, so that I could call them by telephone using a named contact. While I did not speak to any Directors of Nursing, I was able to get contacts, usually in the research

department, for three hospitals, and sent them all brief details of the project by email, asking them to contact me if they were interested in more information. I intended to follow up these emails by telephone after a week or so. I also continued to try and establish contact with the other hospitals on my list.

The Education Director of Northside Hospital called me within a few days, and expressed interest in the project. I sent her a summary and she sent me the documentation for the Northside Hospital IRB. We arranged a meeting, which occurred only 4 weeks after my initial contact and shortly after I had defended my dissertation proposal. I had also sent a draft IRB proposal to her in advance of the meeting. By the time of the meeting, the Education Director had obtained permission in principle from the Chief Nursing Officer for the study and it was agreed that I should submit an application to their institutional review board. I was given contact details for the IRB coordinator so that I could address any queries concerning the application process to her (field notes 08/24/12). The Education Director was extremely helpful and supportive, and believed that the research would benefit the hospital. There were no untoward restrictions placed on my research, and I did not have to modify my research protocol. I offered to produce a policy-oriented report for the hospital, but she asked only that I present my findings to various groups within the hospital (field notes 08/24/12).

At this initial meeting we discussed some practicalities of access, and it was suggested that, with the permission of the Unit Managers, I could visit the units at shift handovers in order to explain the project and recruit participants. Initially I had intended to produce a letter asking for participants, which would be circulated by Unit Managers to CNAs on their units. We agreed that this should be on Loyola University Chicago

headed paper, but that the letter should state that the study had the approval of Northside Hospital; this would emphasize the independence of the study (field notes 08/24/12). In the event I produced a flyer, but this was mainly to post on unit noticeboards.

There were two major complications in dealing with two IRBs. First, Northside Hospital's IRB paperwork was concerned primarily with medical research, so much of it was not relevant to my study, and there were major differences to the Loyola University IRB documentation. In addition, Northside Hospital had a system of fees to cover IRB review of projects. However, their IRB coordinator was amenable to a fee waiver, given the lack of complexity of the protocol and the limited human subject concerns, and to my completing only the paperwork that was relevant.

The second issue was deciding on sequencing, since both Northside Hospital and Loyola University needed permission from the other institution before granting approval. After consulting with the Loyola University IRB office, it was suggested that I could either apply to each IRB sequentially, or apply at the same time, then submit an amendment to Loyola IRB to include the approval letter from Northside Hospital (field notes 09/10/12). Since both institutions had upcoming deadlines in September 2012, and Northside Hospital met only quarterly, I decided that in order to come to a speedy resolution I would submit both concurrently.

Loyola University IRB granted approval of the project in early October, while Northside Hospital requested that the Informed Consent Form (Appendix A) and the flyer I had designed for display in units (Appendix B) should include the Northside Hospital logo in addition to the Loyola University crest. They also requested that these documents include contacts from Northside IRB as well as Loyola for participants who had queries

about the research or their rights as research subjects. Once I had made those amendments, Northside Hospital gave their approval in early November, and I submitted the approval letter and the revised documents to Loyola IRB, who immediately approved them.

The process of finding a site and obtaining IRB approval was much faster than anticipated, mainly due to the cooperation of Northside Hospital. It took only three months from first contact to approval, and I faced none of the delays that I had expected in choosing a hospital research site.

The Site: Northside Hospital and the Nursing Team

Northside Hospital is an independent, non-profit hospital located in an ethnically and economically diverse neighborhood in a major urban center. Based on the zip code data, the racial and ethnic demographics differ from those of the city as a whole; the largest racial-ethnic group is white, closely followed by Hispanics, who make up over one third of the population. There is also a significant Asian population of around 14%, while black people make up only 4%, around one eighth of the proportion for the city as a whole (U.S. Census Bureau 2010). It is a family neighborhood, and while the median household and family incomes are significantly higher than the overall city figures, per capita income is slightly below average levels for the city and the rates of home ownership are also lower (U.S. Census Bureau 2012). This presents a picture of a neighborhood with moderate incomes where higher than average numbers of people within families are in the labor force.

Northside Hospital is a general medical acute care hospital with around 300 beds, an Emergency Room, and some outpatient services. Nursing care is organized around

units, which have moderately specialized functions. There are 13 units within the hospital (although some are comprised of two smaller units with a single manager), and all except the Intensive Care Unit employ CNAs under the supervision of RNs.

Northside Hospital follows the typical nursing hierarchy (see Figure 1), with a Chief Nursing Officer who is a member of the senior management team, and a number of service directors who are responsible for different specialties within the hospital, both medical and other areas like education. Each unit has a Unit Manager (historically called the Matron), and they are the most senior member of nursing staff that CNAs have daily contact with. Staff nurses are responsible for named patients, and for the supervision of CNAs who care for those patients, and most of the data on the division of labor at the unit level refers to the labor process of CNAs in relation to staff nurses.

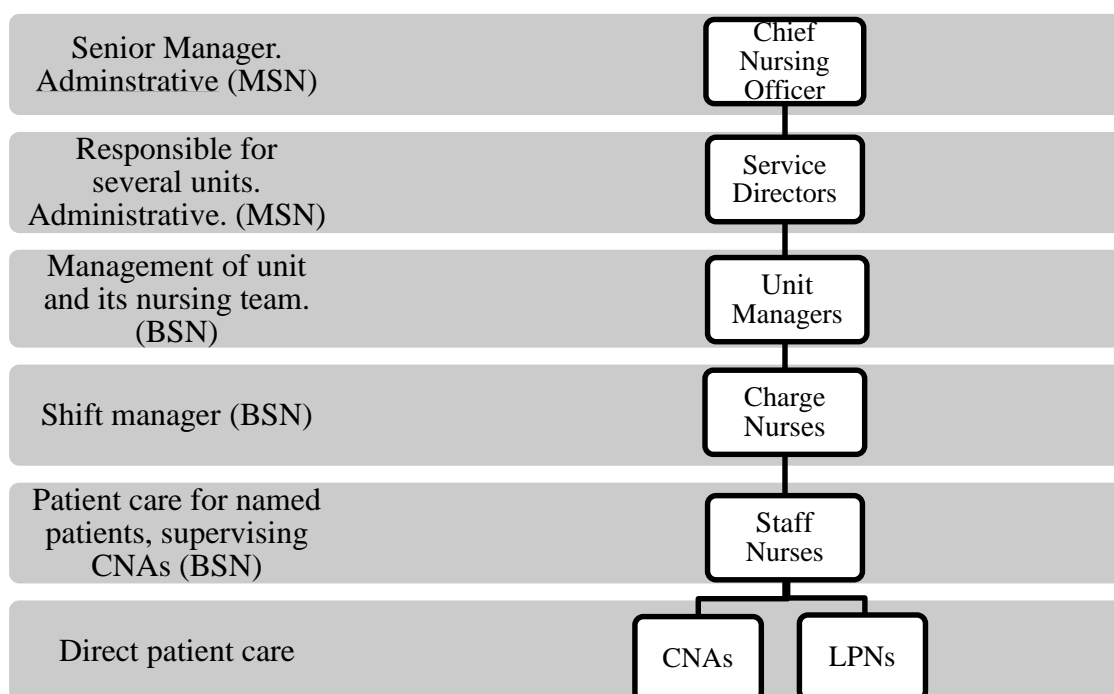


Figure 1. Hospital Nursing Hierarchy (information from Northside Hospital).

Methods

My main method of data collection was semi-structured interviews of CNAs who worked at Northside Hospital. I had initially planned to recruit participants by asking the Unit Managers to distribute flyers explaining the purpose of the research and terms of participation, and inviting volunteers to directly contact me by telephone or email. I would then follow this up by visiting individual units, with the permission of Unit Managers. However, the Education Director invited me to explain the project at a scheduled meeting between the Unit Managers and the Chief Nursing Officer in mid-November 2012 (field notes 11/08/2012). I attended, spoke about the project and gave a handout to all the Unit Managers. I asked if they would be willing for me to visit each unit at a shift handover, and collected their contact details. I immediately followed up by email and was able to commence the first round of unit visits by the end of November 2012. I visited seven units over a period of two weeks, usually at the 7:00am or 3:00pm shift handovers, meeting with CNAs from both the incoming and outgoing shifts. Some units had meetings that included both CNAs and RNs, while others were RN-only, and I met with CNAs separately. In both cases, all the CNAs on shift were not always available, as some were called out to care for patients (field notes 11/26/12-12/10/12).

I had prepared business cards which had brief details of the project on the back, along with a dedicated email address and Skype phone number (see Appendix C). I also placed flyers on notice boards (see Appendix B), and left cards at the nursing station in a card holder, so that CNAs from other shifts could take them (field notes 11/26/12-12/10/12). While I did get some contacts through this method and through Unit Managers encouraging their staff to contact me, it became clear that this was not particularly

effective. For following meetings I produced a sign-up sheet and started asking for CNAs to give me contact details at the shift handovers, emphasizing that this was voluntary and did not commit CNAs to being interviewed. I took phone numbers and/or email addresses. I then followed these up, sending emails with further information to those who provided addresses.

The information required about the research and interview process made the initial emails excessively long, and the request to schedule an interview was difficult to locate within the message. To counter this, I set up a website through the Loyola personal web pages with a page for the CNA project which laid out the information in a Frequently Asked Questions format (see Appendix D). The website did not give any information that would identify the particular hospital, to avoid breaching anonymity, but it did allow me to shorten the introductory email and provide a hotlink to the web page. I could then prioritize the request to schedule an interview in the email itself. As one might expect, some of the younger CNAs were more comfortable with email communication, and I was able to set up some interviews using that medium.

However, it became clear that for most people, the most effective way to schedule an interview was to telephone regularly until I was able to speak directly to the person. I used a basic script to initiate contact, and for answerphone messages. A few people responded to answerphone messages, but most did not. I also experimented with using texts to reach people. These were effective in confirming previous arrangements, and in reminding those who had already agreed, but less so in getting an initial response from people. I was able to call using a Skype number that I had previously set up, and a headset, so that it was easier to record information and book interviews into my online

calendar. Since many CNAs had busy schedules, including attending college, childcare and additional jobs, it was sometimes difficult to schedule meetings. In several cases I agreed to wait until the end of the school term to contact them and arrange an interview. I let people know that I would continue to contact them unless and until they told me they were not longer interested in being interviewed. While it felt intrusive to me to make multiple phone calls to people, I reminded myself that this was a priority to me, but not to my participants: If they wanted me to stop calling, they only had to ask me. Some people gave me their contact information, but never responded to my contacts, despite repeated attempts. Three participants booked interviews then did not make the meeting. In one case, the participant rebooked, and in the other two the participants did not respond to any further contacts.

In order to maintain anonymity, I had originally planned to interview all participants outside of hospital premises, as well as outside the working hours of the participants. However, the Education Director informed me that the Chief Nursing Officer had offered to make a room available within the hospital. The room was away from offices and hospital units, so that interviews could be carried out before or after shifts, for the convenience of the participants. I agreed that if the room was suitable, and confidentiality and anonymity would not be compromised, then this could be an option if participants preferred. I would continue to make alternative venues available outside the hospital as an additional option (field notes 08/24/12). Northside Hospital has a number of discrete buildings, and the rooms offered were part of a block of rooms that were used for training and meetings, located on the first floor at the end of a corridor behind the entry desk of one of the quieter hospital buildings. There was no “passing trade” and it

fulfilled the criteria of providing a quiet and anonymous space that was convenient for participants (field notes 11/08/2012).

I was able to block-book the room for two afternoons a week and at additional times on request. This enabled me to take up to two bookings in an afternoon, with the earlier one catering to afternoon shift workers before they went to work at 3:00pm and the later one to day shift workers who had finished their shift at 3:30pm. Most interviewees preferred the option of being interviewed in the hospital, but I did offer alternative times and places, and interviewed some participants in my office at Loyola. Once I had started interviewing participants, I was able to get some further volunteers through snowball sampling, as some interviewees chose to disclose their involvement with the study to friends. However, I did not disclose the participation of any subjects when asked directly by staff in the hospital, for example, when a Unit Manager said she had recommended a CNA contact me, and asked whether they had done so (field notes 11/26/12-12/10/12).

Interviews took between one and two hours each, with an average of 80 minutes. They focused on the labor process, daily tasks performed and types of interactions with patients and other staff. Further questioning investigated work history and aspirations, work-family balance, and subjects' feelings about the work, particularly the elements of care they provide, emotional labor, and their observations about the labor process and their position in the nursing hierarchy. I also collected demographic information about participants (see Appendix E: Schedule of Questions and Appendix F: Revised Schedule of Questions).

I started off the interviews by asking if the interviewee had any questions about

the research, and then we went through the consent form together. The important parts of the form were explained verbally, for example, the section stating that any identifiable personal and medical information about individual patients should not be disclosed, and that the study was concerned with the work of the interviewee. After the consent forms were signed and one was retained by the interviewee, the \$20 gift card was handed over and signed for by the participant. I recorded all the interviews on a digital audio recorder using the schedule of questions as a basis but asking supplementary questions as appropriate. At the end participants were asked if they had any further questions about the research or any observations to make that had not already been covered.

While most of the data came from the interviews with CNAs, I collected several other sources of data. These included communications between myself and the Education Director, including notes of four meetings and emails from the period August 2012 and July 2014. I also took notes of meetings with other staff, including a meeting of the Unit Managers and Chief Nursing Officer in November 2012 and a presentation by the researcher to the Nurse's Research Group in February of 2013. I also made field notes following visits to units to recruit participants. Between November 2012 and June 2013 I made a total of 14 unit visits, mostly during the 7:00am and 3:00pm team meetings. All units where CNAs were utilized were visited, with three units covered twice to reach different shifts. In some cases I was able to observe part of the team meeting, and the activities around the nurses' station. Notes were also taken after an unscheduled visit to the Emergency Room after a minor injury (field notes 11/26/12-12/10/12).

Finally, the hospital provided reporting data giving details of the number of RNs, CNAs and LPNs in the hospital, and the number of each job title for the CNAs, which

reflected their cross training. This provided useful aggregate data about the staffing breakdown within the nursing team, and the number of CNAs overall who were cross-trained. This data also included information on the gender, racial and ethnic breakdown of broader categories of workers, although not down to the level of CNAs and RNs.

Data Management and Analysis

I recorded the interviews using a digital audio recorder and the audio files were downloaded and stored on a password-protected computer at my home. I transcribed the audio files, and also stored on the same password-protected computer. Each participant was given a number and a pseudonym, and the audio files and transcripts were named using that information. I changed the names at the transcription stage. No identifying information was retained except on the original audio files and on the signed consent forms, which I stored in a locked filing cabinet at my home.

I analyzed the data using Dedoose, an online, cloud-based data analysis tool that guarantees data security and data ownership in its terms of service. I uploaded the anonymized transcripts to Dedoose, then coded and analyzed them to compare factors and themes discussed by subjects. I used grounded theory to note emerging common themes, assess interrelationships among recurring themes and recategorize them into increasingly abstract levels of analysis. The concepts that emerged from earlier interviews were then used to develop new questions for later interviews, to explore those concepts in greater depth (Charmaz 2006; Strauss and Corbin 1990).

Interview Participants

I interviewed 21 CNAs in total. All but two were full-time employees (defined as 32 hours or more per week). One worked part-time and another worked as needed.

Participants worked in eleven different units within the hospital, under nine different Unit Managers.² The units included several medical surgical, orthopedic surgical and cardiac telemetry units, rehab units (specializing in both cardiac and orthopedic rehab), the Intermediate Care Unit (the IMCU is a high-care, step-down unit from the ICU), and the outpatient day surgery and wound care units. I was not able to interview anyone from the Emergency Room- while a few CNAs are cross-trained as Emergency Techs, most Emergency Techs are certified as paramedics or emergency medical technicians.

Table 1 shows the pseudonyms and selected characteristics of my sample. The CNAs I interviewed ranged in age from 19 to 64, with a mean age of 37 and a median age of 34, and included four men. Ten of my interviewees were Hispanic, and all of these were bilingual in Spanish and English. Four participants identified as multiethnic, and three of these had one Hispanic parent, although none of these participants were bilingual. Four other interviewees were fluent in one or more languages apart from English, including Tagalog and Greek. One CNA spoke several Indian languages (Hindi, Malayam, Kannada and Tamil) and another spoke several African languages in addition to French. These language skills were significant, since one “unofficial” task performed by many CNAs was acting as interpreters between patients and other hospital staff.

Five participants lived in a house or condo that they owned, 13 rented their housing (all but one in apartments), one lived with her parents, and one lodged with a family. Eight of my interviewees were single, five were married, three cohabited with

² There were some complications in establishing the number of units in the hospital. While the Education Director mentioned 13 units, this actually refers to the number of unit directors. Some unit directors manage two smaller units, and CNAs are attached to a specific one of these smaller units, so while CNAs came from 11 named units, this refers to 9 out of 13 Unit Managers.

partners and five were divorced. Thirteen had children, from one to five each (average, two and a half) including all the CNAs who were over 35. Seven were single parents, including one male CNA. Nine had children under 18 and all of the women and one man in this group had these children living with them.

Table 1. Selected Characteristics of Interviewees.

<i>Name</i>	<i>Age</i>	<i>Gender</i>	<i>Race/ Ethnicity</i>	<i>Unit Assistant</i>	<i>Specialist Cross Training</i>
Alex	28	F	multiethnic	✓	
Angela	55	F	Hispanic	✗	HBO tech
Anne	19	F	Indian	✗	
Charles	26	M	white	✗	PCT
Daphne	48	F	white	✓	Scrub Tech
Elena	30	F	Hispanic	✓	
George	26	M	multiethnic	✗	
Graciela	38	F	Filipino	✗	
Isabella	61	F	Hispanic	✗	
James	36	M	Filipino	✗	
Laura	23	F	Hispanic	✓	Monitor Tech
Leah	25	F	white	✗	
Luciana	51	F	Hispanic	✓	
Maria	35	F	Hispanic	✓	
Marta	27	F	Hispanic	✓	
Melanie	23	F	multiethnic	✓	
Ruth	34	F	Hispanic	✓	
Sandy	64	F	multiethnic	✗	
Sofia	32	F	Hispanic	✓	Scrub Tech
Teddy	56	M	black African	✗	PCT
Yolanda	40	F	Hispanic	✓	

Sample Representativeness

Since my sample consisted of qualified people who volunteered to be interviewed, it is likely to be unrepresentative of the group as a whole. Those people who were willing to be interviewed may have more commitment to their job and have thought about it more. They may have higher levels of education than the average among the CNAs at Northside Hospital, but I do not know for sure. Compared to national figures, the participants in my sample had considerably more education. Overall, only two participants had the CNA training as their highest level of education, both women in their 60s. Two had completed training as Medical Assistants, five had associate Degrees, eight were currently enrolled in college courses (including two at four-year colleges), and the remaining four had attended college, but not graduated. While Yamada (2002) found that almost half of nursing assistants in hospitals had some college education, even discounting those who had Medical Assistant qualifications, fully 81% of my sample had some college education. It is unlikely that this is representative of the education levels of CNAs at Northside Hospital, but I do not have data to demonstrate this. However, it is notable that I was unable to arrange interviews with several CNAs who stated that they were too busy with college to be interviewed.

Several CNAs mentioned colleagues who were lazy or uncommitted to their job. However, while people being interviewed are unlikely to admit to laziness, it is also less likely that those kinds of CNAs would volunteer for interview. Charles, a young male CNA who had considerable college experience, made the point that it was a secure job, paying above minimum wage, and required little investment of time and education to become qualified and get a job, meaning that some CNAs had little commitment to high

standards of care. He articulated his view of different motivations of CNAs, dividing them into three categories:

The attitude of how the various CNAs approach this job is often dependent on why they're here in the first place. . . . [T]here's a number of CNAs who are going on for further, . . . very motivated and very focused and very driven and working hard, and trying to learn more and they're tenacious, it's wonderful. There's another segment that are here because they're excellent caregivers, but they're not going to go further with their education; this is their forever job, and they like it, or even if they complain about it they do it and they do it great job and, they do it with a smile in their face. . . . And then you have another section that at times can infuriate me. They're a CNA because they could become one. . . . For that segment of the CNAs, who have this because it pays well, because it's just their J-O-B, it creates a very noticeable difference in the work environment and how they approach the CNA job, different from a lot of other work environments (Charles, personal interview, June 18, 2013).

While it is not possible to gauge how representative the sample of CNAs interviewed is compared with the population of CNAs at Northside Hospital, they did include people with a wide spread of age and experience. This, and the range of types of units that the participants worked in, meant that rich data was available on the labor process and division of labor within different units. The range of cross-training of interviewees was useful in highlighting specialist tasks that were performed in specific categories of units.

In Chapter Three I discuss the labor process of CNAs and the division of labor between them and other staff, particularly the RNs they work with. I discuss the major changes in the division of nursing labor over time, and the larger institutional factors that have been behind these changes. In particular, changes in healthcare institutions since the 1970s have meant diversification of healthcare delivery, so that many auxiliary nurses were moved from acute care settings to nursing homes and outpatient clinics. A second influence on the division of nursing labor has been the attempts of nursing leaders and nursing organizations to improve the professional status of graduate nurses This has

meant, at various stages, the promotion of RNs as team leaders and supervisors of the nursing team, or as primary nurses responsible for the whole range of nursing tasks, including bedside care. These two institutional factors have affected the labor process of CNAs and their deployment in hospitals. The next chapter explores these issues in depth.

CHAPTER THREE

OCCUPATIONAL BOUNDARIES AND THE CHANGING ROLE OF CNAS IN THE PRODUCTION OF HOSPITAL NURSING CARE.

Nursing care is the backbone of hospital work, and nurses and nursing auxiliaries make up the largest occupational group within hospitals, around 40% of all hospital staff (Bureau of Labor Statistics. 2014a). However, they have also been the group most affected by profound changes in the organization and funding of healthcare in the United States, and have been particular targets of efforts to improve efficiency and contain costs within healthcare (Brannon 1990; 1994a; 1994b; 1996). Nursing assistants and male orderlies have worked in limited numbers in hospitals for as long as hospitals have existed in the United States (Bullough and Bullough 1978). However their number has increased and their role changed since World War II. The story of the increasing role of nursing assistants is linked to a number of changes in hospital care, including increasing rates of hospitalization, new technology and changes in the nursing labor process, which have developed in relation to changes in the training and status of nurses, and to new priorities in hospital management and accreditation.

Fundamental changes over the last 60 years have transformed hospitals into corporations that provide healthcare services in a variety of settings. The era of cost containment that started in the 1970s meant less autonomy for hospitals and physicians in the provision of services, as they came under pressure from corporate and state

purchasers of services (Brannon 1990; 1994; 1996). Most sociological studies have focused on the effect of these changes on medical and nursing professionals, while largely ignoring other occupations in the health industry, most of which are overwhelmingly gender segregated. The effects of these changes on the status of women's occupations may be even greater than that on the medical profession (Brannon 1994a).

Nursing Labor Process

While there was some limited use of maids, aides and orderlies in hospitals in the late nineteenth and early twentieth century, most nursing care in hospitals before World War II was provided by student nurses training for their diploma at nursing schools attached to hospitals (Brannon 1990; Bullough and Bullough 1978; Malka 2007). Most "diploma"¹ courses lasted two years, and had little academic content, with students working on the wards for 12 hours a day, six or seven days a week (Bullough and Bullough 1978). However, during the 1920s and 30s, developments in medicine and surgery led to an exponential increase in the number of hospital beds, from around 35,000 in 1873 to 770,000 in 1923, and the need for both more experienced and greater numbers of nurses (Bullough and Bullough 1978). Leading up to the Second World War there were critical nursing shortages and the Red Cross was asked to train 100,000 nurses' aides per year to meet the wartime need for care. Training included 80 hours of theoretical and practical instruction, took no longer than seven weeks, and those who passed received certification². The aides were required to work for 150 hours in a hospital

¹ Diploma courses at nursing schools terminated in the RN certification.

² It is noteworthy that this training schedule is comparable to that of present CNA training.

on a voluntary basis. By the end of the war, 212,000 women had been certified and were working in 3000 hospitals. Hospital administrators could see the value of employing less qualified workers to do the more menial jobs, and many were able to take up paid positions, with some later becoming Licensed Practical Nurses when that certification was introduced in 1950 (Bullough and Bullough 1978).

After the war, the demand for both RNs and auxiliary nursing staff increased even further due to the growth of private health insurance and the decline in nursing student labor. The number of patients being hospitalized increased dramatically, while lengths of stay began to reduce due to improved medical technology, and to the requirement to control labor costs (Malka 2007). This led to several waves of reorganization of the nursing labor process which have meant fluctuations in the use of auxiliaries (including nursing assistants and Licensed Practical Nurses) in hospitals, and which have been met with varying degrees of support from nursing elites and from frontline RNs. These have included team nursing, primary nursing and a return to a different form of team nursing under the rubric of quality management. As the largest hospital-based occupation, strategies for increasing efficiency and reducing labor costs have particularly targeted nursing staff (Brannon 1990; 1994a; 1994b; 1996).

In the period immediately after World War II both hospital administrators and nursing leaders began to differentiate between the delivery of “nursing care” (which could only be provided by RNs) and the establishment of a “nursing service” provided by a team of workers with different skill levels (Reverby 1979). Team nursing was introduced to integrate these stratified nurses into a common labor process, with RNs as team leaders supervising a hierarchically-subdivided set of tasks, the classic Taylorist

division of conceptualization and routine task performance (Brannon 1990; Braverman 1974; Bullough and Bullough 1978; Malka 2007). Nurses were responsible for reading and interpreting doctors' orders and planning and recording patient care, as well as allocating and supervising the routine bedside care and less skilled tasks performed by auxiliaries, and evaluating their performance (Brannon 1990; Bullough and Bullough 1978; Malka 2007). As the "touch" tasks were increasingly undertaken by LPNs and aides, nurses were urged not to be too sentimental about patients, replacing the traditional "caring" ethic with one of rationalization and efficiency. "At times, nursing work seemed to prioritize the order and symmetry of the hospital ward over patient comfort" (Malka 2007:19).

Rather than professional autonomy, nurses had "responsible autonomy" (Friedman 1997), being caught between formal hierarchical responsibility to physicians and managers and supervision of auxiliaries who performed bedside care and who had more direct knowledge of individual patients. This means that RNs were responsible to their managers for care that they did not themselves give, while auxiliaries became empowered by their practical experience and their greater familiarity with patients (Brannon 1990; Reverby 1979). In addition, the higher proportion of auxiliaries to RNs in team nursing meant that the formal subdivision of labor was often violated. RNs resented asking LPNs to perform tasks reserved for graduate nurses, because it undermined their authority and the legitimacy of the task subdivision, while auxiliaries resented doing the tasks, feeling they were doing all the work without recognition (Brannon 1990; 1994a; 1994b).

The lack of firm occupational boundaries were particularly problematic for RNs

since there was considerable overlap between the tasks that LPNs were licensed to do and the work of RNs, meaning that substitution could occur, driving down wage differentials and undermining the ability of RNs to achieve social closure (Brannon 1994a; Reverby 1979). By the late 1970s, the wage differentials had narrowed so much that the replacement of auxiliaries with RNs was seen as economical, as their training and credentials made them a highly flexible workforce who could be more productive overall (Brannon 1990). This changeover served the needs of a number of different groups. Healthcare organizations were looking to expand into peripheral healthcare, meaning that less critical nursing care could be performed outside hospital settings by cheaper auxiliary workers, meeting the desire of health care managers for greater productivity and cost control (Brannon 1990; 1994a). Nursing leaders hoped that primary nursing would serve their professionalization agenda. Under primary nursing RNs performed the full spectrum of nursing tasks on the ward, including bedside care, giving them autonomy within the nursing hierarchy and an unmediated relationship with patients. Frontline RNs were no longer responsible for care they did not give, which was a major cause of frustration that had emerged with the subdivision of the labor process (Brannon 1994a;1994b).

In the late 1960s, at the height of team nursing, hospital nursing comprised 70% auxiliaries (including LPNs) and 30% RNs. By 1986, it had almost reversed, to 60% RN and 40% auxiliaries, with proportions as high as 85% RN in some hospitals (Brannon 1990; 1994a; Sacks 1988). During this period there were over two million RNs, and record enrollments in credentialed programs, but there were still nursing shortages. Since RNs were no longer vulnerable to staff substitutions during industrial actions, they were

able to negotiate better pay and conditions (Brannon 1994b; 1996). However, this meant the already marginal cost savings to the organizations were reduced. By the 1990s, productivity improvements became less important to management, particularly in light of the industrial unrest from empowered nurses (Brannon 1994; 1996)

In response to this and to the popularity of the Japanese Toyota Production System in American management circles, many hospitals examined their labor processes and introduced a new division of labor based on lean production models from industrial settings under the banner of “Continuous Quality Improvement” (CQI) and “Total Quality Management” (TQM) (Nelson-Peterson and Leppa 2007; Spear 2005; Viswanathan and Salmon 2000). These systems were designed to break down occupational barriers and work jurisdictions and rationalize hospital work production. They also claimed to empower workers by enlisting their participation in the planning of the labor process through team-based work groups that had flexibility in performing tasks, and by increasing skills through cross-training (Nelson-Peterson and Leppa 2007; Spear 2005). However, critics argue that improved productivity and reduced labor costs through lean production actually result in intensified workloads for the remaining cross-trained workers, particularly since the new corporate healthcare model meant that patients being treated in hospital were more likely to have acute needs (Brannon 1990; 1994a; 1994b; 1996; Sacks 1988). As CQI was officially endorsed by the Joint Commission on Accreditation of Healthcare Organizations as a central component of health care quality assurance, accreditation of hospitals became linked to this strategy (Brannon 1996; Viswanathan and Salmon 2000)

In some early transitions, this redesigned team program replicated the earlier team

nursing staffing ratios, reducing RN staffing by up to half and removing them entirely from bedside care and into supervisory roles as “Care Coordinators” (Brannon 1996). However, the long-term picture is more complicated. In most hospitals RNs were retained as the largest proportion of the nursing team, while LPNs were gradually phased out. In 1984, over half of all LPNs worked in hospitals. By 2001, this had declined to a third, with a fall of 5% between 1993 and 1994 alone (Seago et al. 2004). However, LPNs were retained in larger numbers in for-profit and in government hospitals, where cost-cutting was prioritized and LPNs were substituted for RNs (Seago et al. 2004). There are also regional differences, with higher proportions of LPNs in the South and the lowest in the Northeast (Seago et al. 2004).

At the present time, RNs make up around three quarters of the hospital nursing team nationally, and CNAs are at 17%, while the proportion of LPNs continues to decline, currently making up only 7% of the nursing team in hospitals (see Figure 2). The removal of most LPNs from hospital care reinforces the occupational boundaries within the nursing team. CNAs cannot substitute for RNs since they are prohibited from passing medications, changing dressings, setting up or changing IVs or providing any medical interventions. On the surface, it looks like the CNAs’ place in the hospital setting has been downgraded and relegated to second-class status. However, as this research shows, and as seen in the rest of this chapter, the emphasis on producing a flexible workforce has given CNAs greater opportunities for cross-training and specialist training. Furthermore, the increased specialization of RNs, and their role as supervisors and managers of nursing care, means that in most units CNAs are the staff seen most regularly by patients, delivering the bulk of bedside care and comfort work.

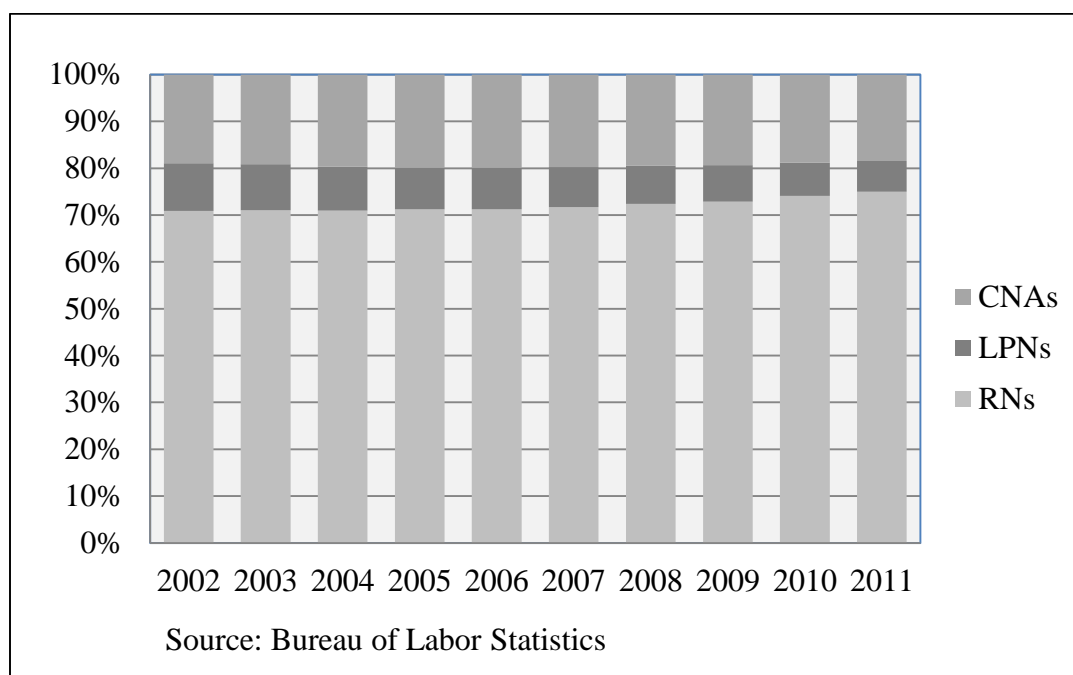


Figure 2. Breakdown of Nursing Team in General Hospitals, 2002-2011.

Findings

Northside Hospital and the Nursing Team

Northside Hospital's use of nursing staff differs from the national picture (as far as this is known) in some significant ways. It has Magnet status for excellence in nursing, and recruits RNs with baccalaureates (BSN), rather than those with associate degrees (ADN) or diplomas. Senior managers typically have MSNs. Northside Hospital is at the forefront of policy recommendations: nationally, only 50% of RNs have a baccalaureate or higher degree, but several influential reports from health policy and nursing leadership organizations have urged that the baccalaureate should be the standard educational requirement for RNs (Institute of Medicine 2011; American Association of Colleges of Nursing 2012).

At Northside Hospital, there is an even clearer division between RNs and

auxiliary nurses than the national picture discussed earlier. Northside employs 525 RNs, making up 72% of the nursing team, which is slightly less than the national average. CNAs make up 27% of the nursing team (compared to 17% nationally) and there are only six LPNs, less than 1% (data provided by Northside Hospital). Northside Hospital employs over 200 CNAs, and they can be found in all units apart from the ICU, a total of 12 units. This means that in the majority of units, the division of nursing labor involves only highly-qualified RNs and CNAs, who have a state-level certification.

Shifts and Workload

The core tasks of CNAs in hospitals are centered around the personal care of patients, but the particularities vary according to patient needs and mobility. Units are specialized to varying degrees, so that some units have patients who are not very mobile and need different kinds of personal care to those units where patients are able to get out of bed and walk around. Some units, day surgery and wound care, are out-patient; in the first case, patients are seen briefly before and after surgery, usually for a single event, while in the second, patients come from inside or outside the hospital on a regular basis, often for several weeks.

Most CNAs at Northside Hospital work according to the usual hospital three-shift pattern of day, evening and night. Shift changes are at 7:00am, 3:00pm and 11:00pm, with half-hour handovers. However, there are some units such as Day Surgery and Wound Care that are outpatient clinics that operate only during the day, usually from 8:00am or 8:30am to 5:00pm or similar, and the IMCU and obstetrics units work on a 12-hour shift, changing at 7:00am and 7:00pm. There is, however, a certain flexibility, so that some CNAs have negotiated different hours according to their personal

circumstances, and on some units, when CNAs are scheduled to work as Unit Assistants they may work daytime hours from 9:00am to 5:30pm to accommodate the busy times for admissions and transfers.

Most of the CNAs I interviewed were full time, which includes some on 40 hours per week, and others on 0.8, or 32 hours (which is still considered full time). Rosters for in-patient units are usually the responsibility of a charge nurse who draws them up on a monthly basis. CNAs have some flexibility in choosing shifts; while most are appointed to a regular day, evening, or night shift, some float between those or do regular double shifts as a choice. CNAs are expected to do alternate weekends, but some CNAs, particularly those at college, choose regular weekend shifts to accommodate their study schedule. In most units, a charge nurse draws up a provisional schedule, and CNAs can negotiate for the shifts they want, and are expected to complete their contracted hours over a two-week period. If there are conflicts, they will often arrange with other CNAs to swap shifts, or if this does not work, they will approach the Unit Manager to find a solution. Sofia and Ruth work on different units, but make similar points that emphasize the flexibility of the shift system at Northside Hospital. Sofia, a 32-year-old CNA who works 12-hour shifts on the obstetrics unit explains:

We are very lucky to have this one girl that works in our unit and she makes our schedule, . . . it's like a month long. . . . So I would suggest or I would tell her okay, I'm free these days and I would rather not work these days and then she'll accommodate. If by chance there's a day that I really didn't want to work but I am stuck working. I try to switch with another colleague and if I can't do it, then I can't do it. Then I have the option to come in or maybe call in sick. But I usually try not to (Sofia, personal interview, June 13, 2013).

Ruth is working part-time on an undergraduate degree at a local college, so appreciates the opportunity to work around her class schedule:

I share a shift with, with another girl, as we both go to school, so the days that she's in school I work, and the days that I'm in school she works. So, it's more, I would have to say, my supervisor kinda leaves it up to us, where she says, "You guys figure out your schedule – if there's a conflict, then, bring it to me" (Ruth, personal interview, November 30, 2012).

The number of CNAs on a particular shift varies according to the census (number of patients). Most inpatient units at Northside have around 18 beds, although at least one is double that size. Unit Managers are responsible for two of these smaller units, which will typically have two CNAs per shift, while RNs are responsible for three to five patients, depending on the level of care required. CNAs split up the rooms, usually by side, so that each aide takes care of up to nine patients, although this can rise to twelve in some cases, since if the unit census (occupancy) drops below a certain level, one CNA is usually reassigned to another unit or sent home. However, it is not unusual for new admissions to raise the census during a shift, intensifying the workload of the remaining CNA.

CNAs also feel under pressure if they have a heavy caseload of "complete" (complete care) patients. These are patients who are immobile due to their medical condition, or because they are intubated or have a tracheotomy. These patients require considerable care, including turning every two hours, and may also be incontinent, requiring regular diaper changes and clean-up. They also need regular checking, since they may not be able to speak and use the call-light system. The people I interviewed did not mind the tasks associated with complete patients, but did feel that the extra work was not always considered in allocating staff.

Another task that was heavily resented was dealing with "sitter cases." These are patients that need to be observed constantly, usually because they are at risk for harming

themselves because they are suicidal, or they are withdrawing from drugs or alcohol.

CNAs must sit in the room and be within a few feet of the patient at all times, and this is generally for the whole shift, although CNAs may divide this duty up. This puts extra strain on the other CNAs, since they must cover all the other patients in the unit. You don't generally become a hospital CNA if you enjoy sitting around, and many CNAs specifically say that they like to keep busy and they have a sense of responsibility for "their patients," so this job is seen as frustratingly unproductive time. Maria described being torn when she was unable to help with an emergency on the unit, because she was with a "sitter case" and had to try to calm down her patient, who wanted to get involved:

I had a very heavy side, and then I also, to top it off, I also was a sitter case for one of my suicidal patients. And everybody was busy, I understand that, but . . . it's very hard and it really upsets me that I have to sit there with a patient. I know patient is suicidal, I know, but we could get somebody else to come and sit. It was a terrible week, because we had a patient who was coding on my side. They were doing a bedside procedure, and she fainted, so they pressed the code. I was in the room, they needed my help. I couldn't do any – I felt helpless, because I was with this patient who was suicidal, who was there and, "What's going on? Tell me." And really, really wanted to be nosy. You need to stay in the room, and I tried to calm her down (Maria, personal interview, February 11, 2013).

Northside Hospital has been advertising for people to take on this role as needed, with a recent (and recurring) advertisement requiring no specific qualifications except a high school diploma, effective verbal and written communication and the ability to sit still for long periods (Job advertisement for Sitter, Northside Hospital website). However, this job still falls on CNAs on many occasions.

There are usually opportunities for overtime for CNAs, although this varies by unit. Some units try to minimize overtime, while others may ask CNAs to stay on past their shift or take on extra shifts. CNAs who want to work extra shifts can also contact

the central nursing office to find overtime on other floors, although this is easier if it is a floor where you have previously worked, and know the set-up.

Core CNA Tasks and Routines

On the in-patient units, each shift starts with a handover, but the form of this varies by unit. In some units, the day shift team meetings (or “huddles”, as they are often called) includes both RNs and CNAs, led by the Unit Manager or the Charge Nurse, although CNAs are frequently called out of these meetings to attend to patient needs. However, in all units CNAs take a report from the departing CNA. This report usually includes just the kind of information that is necessary for the personal care delivery, rather than medical details. This might include whether the patient is complete care, if they need regular turning, if they are able to get up to use the bathroom or need bedpans or diapering, their levels of alertness, any conditions that would affect how they are turned, for example, orthopedic issues, and sometimes information about the temperament of the patient that would help the CNA in judging the best way to give care.

Charles gives an example of the kind of information that is passed on:

[We] explain what happened on the shift to relay information that’s important, communicable diseases, even if it’s not the CNA’s individual responsibility. “Just to let you know, if you’re going to help that patient, please be cautious. Please wear gloves if you want to do this. This patient was confused, this person is on restraints, this person is abusive, this person is combative” etcetera . . . so that everyone has a fair game (Charles, personal interview, June 18, 2013).

In units where CNAs are not part of team meetings with the RNs and Unit Manager, some CNAs resent that medical information is not passed on, because the departing CNA does not have it. For example, Luciana, a CNA with 15 years’ experience, compared the practice on her unit at Northside with another hospital where

she had worked previously:

Here, it's the other CNA gives you report, but . . . you don't have a report with all the nurses . . . Most of the time I don't even know what's going on, unless the nurses come and tell me. But in [the other hospital] I used to hear report, and I knew what was going on. The patient is gonna go to this, if we're doing this, we're doing that. I knew, I was hearing everything already (Luciana, personal interview, February 18, 2013).

She felt that the lack of medical information she had hindered her ability to give the best care to patients:

When I get here, she's just telling me, oh, he can get up, he can do this. I didn't even know they had surgery, for God's sakes! Because she didn't tell me all of that, she's just telling me, oh, bedpan or this or that or, you know. That's not a report, that's not a report. I need to know what's wrong with the patient. Why is the patient here? You know what I do? I go to my computer and I check. I go, why is this patient here? I check myself to see what's wrong with them, and this and this and that. I don't know, these people are not giving you the proper things, so I don't rely on nobody. I just know what they tell me. They even tell me the wrong things sometimes, for God's sakes (Luciana, personal interview, February 18, 2013).

The “best practice” way of doing the handover is to go into each room, introduce the new CNA (waking up the patient, if necessary), write details of the new staff on the whiteboard, and discuss the patient there, this does not always happen. On night shift, which starts at 11:00pm, the patient may be asleep and the handover information may be given outside the door, so as not to unnecessarily disturb the patient. In some of the more long-stay units, such as the extended care facility, the CNAs may already know the patient history, and an update may take place at the nurses' station. However, in units that have a greater proportion of high-care patients, the handover may provide an opportunity to turn patients or move them into a seated position for breakfast, tasks that require, or are much easier with, two people. Maria, who has worked in healthcare all her life, explained the procedure:

We go ahead and turn them every two hours. So, I don't wait for the nurses, I actually like to make sure that my patients are nice. So when I go give rounds to them with a CNA I always make sure that, okay, then, when was the last time? "Oh, I just cleaned them so we just turned them." Okay, so I don't need to turn them till 9 o'clock. But if they're, "Oh no, we haven't turned this patient," or if I don't see no pillows there, "Oh, is it okay with you, while you give me report, can we go ahead and turn the patient?" They're like, "Okay" (Maria, personal interview, February 11, 2013).

The first order of business after the handover is taking vital signs for each patient, including blood pressure, temperature, pulse, respiration and oximetry, which are taken using the Dinamap cart (vital signs monitoring equipment), writing the values down on a sheet and then entering them in the computer, which is usually done when all of the readings have been taken. This is often combined with a more general "rounding": introductions, checking out if patients need water or help with toileting, as well as noting which patients might be in need of a bath on that shift. After that, diabetic patients have their glucose testing, the only procedure that CNAs do where they are permitted go inside the patient's body. Elena gave me a rundown of a particular afternoon shift, starting with the handover with the departing CNA, which echoes that of workers in similar units:

We go in the rooms, say "hi" to the patients. But we just really say. "You're in good hands and I'm leaving," just to say "Bye," . . . so they're not, "Who is this person coming to my room?" After that we usually just take vital signs at my shift and I just ask them if they need anything else, things that they feel comfortable in, just the general work. Afterwards I put all the vitals in the computer, report any unusual vital signs to the nurse. After that I just go and check to see if there's anything else needed to be done, like if they need a blanket, little things, water. Around, like, five or so we start doing, if needed, AccuChek [glucose testing] on patients and dinner usually comes round 5:30. I will go in there, check they got food set up, if needed we feed them. . . . After that . . . we mark what they ate, around six, 6:30, before they start taking the trays back to the cafeteria or wherever they go. And then from there at seven or so I usually go on lunch myself, have to eat, myself! . . . At eight or so I go back, make sure they're OK again and turn patients- every 2 hours we turn our patients, whoever needs to be turned, bathroom breaks or whatever they need. Around 9:00 start going in their rooms, any patient that has Foleys, JP tubes, anything, drain them. I usually go in

there, start cleaning the rooms up, for my shift that's what I do, make sure it's clean for the next shift coming. So blankets, anything that's dirty, I just take it all out, garbage. Around 10:00 also I start putting in what I've done for the day, like if I did any baths, . . . how much the patient ate, how much they urinated, how much the tubes are. I report it back to the nurse too, because then the next shift that's usually coming in around 11:00, so now I'm writing in my report so the nurse can give what I done to the next nurse too, as well (Elena, personal interview, December 3, 2012).

Vital signs are generally taken twice on each shift, although this varies according to the unit and the individual patients; for example those who are having chemotherapy or blood transfusions need to have vitals taken every 15 or 30 minutes, or hourly. However, the routine taking of vitals provides a structure to the shift, along with the two-hourly turning of "complete" patients. CNAs usually organize their own tasks within these pre-set schedules. Most of the CNAs I interviewed were very experienced, and resented being micromanaged by certain nurses. George, an experienced CNA who is in school studying to be a respiratory therapist, found it particularly galling:

I would say a bad shift would be—it's normally a certain staff I would work with who would try to be by the book. . . . They don't really see how I'm working and they would just try to remind, it's like I don't like to be reminded. I know—I've been doing this probably six years now and I already got my rhythm, everything is going well. Like, I pretty much know how to do everything right and the thing that would get to me is, like, when they start telling me about the rules and all the stuff when I already know it (George, personal interview, June 4, 2013).

Luciana described her system for making sure patients were bathed. This can be time-consuming for patients who are less mobile, and if there are a lot of "complete" patients, all of them may not get bathed during a single shift:

I start with the completes and the people I know they can't get up and do nothing for themselves, those are my targets first. Then I do, initially, the elderly females and elderly men, and I go change them, make sure they're nice and clean and everything, so that way I don't have to worry any more, I'm like, okay, they're clean, they went to the bathroom. And the other people that they are up and around, "Okay, here's your towels," I remind them, "You can take a shower. If you need my help, I can help you, no problem, you know, don't be shy, I'm

there.” I say, “I’m too old, I’ve been here too long, don’t worry, don’t worry about me,” so, you know. And I try to encourage them, “Clean up,” or whatever, you know, “You’re perspiring. Let me change the sheets, you know, you go to the bathroom and” – it seems like we have to be behind them. . . . I know they’re not feeling well. I know that they need to be cleaned and everything, but if they’re feeling like, “Oh my God, don’t even touch me or move me, cause I feel like throwing up”, I’m not gonna be on top of that person. So, I say, “I’ll see you tomorrow. I’m here all week, so I’ll get you tomorrow” (Luciana, personal interview, February 18, 2013).

Baths that do not get completed during the day are passed on to the night shift, and there is generally a target number of baths that CNAs are expected to complete on each shift, to ensure that the work is distributed evenly.

On some units with a large number of complete patients, like the Intermediate Care Unit (IMCU) CNAs and RNs try and combine bathing and treatment, with CNAs bathing on one side of the bed, while the RN checks wounds and changes dressings, tracheotomy and feeding tubes, on the other side. This is a high care unit, with a 1:3 ratio of nurse to patients, so RNs and CNAs are more likely to work together. The bathing and wound care is time consuming, and easier to do at night, so while most night shift CNAs have a target of two baths each, on this particular high-care unit, each RN is expected to complete at least one bath per night shift with a CNA. However, patients often need to be cleaned at other times, as well.

Patients who are mobile are encouraged to use the showers, either alone or aided by the CNAs if necessary. Sick and weak patients may need encouragement from CNAs to get out of bed and complete these personal hygiene tasks. Getting patients out of bed gives the CNAs an opportunity to change sheets and gowns and clean up the room, and the patients often feel much better when they are clean, since some conditions and medications lead to excessive perspiration and flaking skin.

Types of Units

While there is a common core of tasks around personal care and taking vital signs, the form that personal care takes, and the specific tasks, tend to vary according to the unit, the particular conditions the unit specializes in, and the level of care required. In addition, there are particular forms of cross-training that apply to specific units to meet the specific patient care needs on those units. CNAs are used in all units except the ICU, and units vary by specialization and level and type of care, although most units cater to a variety of conditions, and may have overflow patients that cannot be accommodated on any other units.

Ortho surg, med surg and cardiac care units. Most units in the hospital are described either as ortho-surg, med-surg or cardiac care. In addition to this there is the IMCU, or intermediate care unit, which provides critical care at a level below the ICU, and where patients may be transferred from other units if their condition worsens. Some of the other units provide critical care and post-surgical intensive care (but not at the level of the ICU proper), some specializing in orthopedic surgical cases or medical surgical and oncology cases, and others cater to cardiac patients. Patients may enter the units directly from the Emergency Room, or be transferred there after surgery or be directly admitted by their primary care physicians.

Cardiac units are generally set up for telemetry, a machine which monitors some or all vital signs constantly so they can be observed on a monitor screen at the nurses' station. The CNA is often the person who attaches the equipment to the patients. Since cardiac patients are encouraged to be out of bed and to take exercise, some of these are ambulatory monitors that have packs that fit into the gown pocket. However, even those

on monitors have temperatures taken by the CNAs.

Turning and lifting are important tasks that require skill, knowledge and practice. Turning of complete patients is done on a two-hourly schedule as a preventative for bedsores, but is also required for bed baths and for placement of bedpans. Other patients may need to be pulled up into a seated position for mealtimes or for their own comfort. Patients who can get out of bed, to use the bathroom, to sit in a chair or to walk the halls for exercise may need assistance, and some units use a gait belt, which is a strong webbing belt with handles that the CNAs attach to the patient to help them get upright, or to support them while they are walking.

Techniques for turning patients so as not to cause injury or excessive pain depend on the condition of the particular patient. This is particularly important on orthopedic units, where patients with back injuries will need a different set of steps from people with hip injuries. Some CNAs use quiet times to practice moving different kinds of patients on each other in a spare room. The cost of getting it wrong can be high:

One day I got report, complete patient just came. That's all I knew. So the patient asked me to give her the bedpan and I went there to turn her and she was screaming. I'm like, what's going on with you? And then the husband came and he was upset. "Don't you know she has a broken hip" "Oh my God," I said, "Why didn't the nurse tell me?" This poor lady, broken hip, I'm trying to turn her. I need two people or more, put pillows, making her comfortable when I'm turning. I mean, I could have damaged her more (Luciana, personal interview, February 18, 2013).

However, even on the cardiac units, people who have had pacemakers fitted are unable to raise their right arm, and those who have wounds from the insertion of cardiac catheters must keep their leg straight in order not to re-open the wound. The CNAs must be aware of all these issues before they turn the patient, and in most cases two CNAs would be

preferred, although they are not always available. Being turned correctly makes a huge difference to patients in pain. Alex's expertise and her clear instructions to a patient led to a successful outcome and the gratitude of the patient:

I said, "Sir, you just gonna have to trust me and just do as I tell you. You're going to reach for the railing on your right side, so that's all you have to do, the rest of us will take care of it." So my coworker's pushing him while I'm holding his leg and properly turning him, and it was without pain. And we put the bedpan on properly, he was able to go, we cleaned him up, and when he was done, he just said, "Oh my God, you ladies are angels. It's finally great to have somebody who knows what they're doing" (Alex, personal interview, January 15, 2013).

As Strauss points out (1997), the therapeutically-oriented work schedule in acute hospitals competes with comfort work, which, while it may be very important to the patient, has a low priority unless it is seen as a symptom of the patient's condition, or as something affecting the course of their illness. The comfort work of the CNAs is often interrupted by tests and therapies that they must prepare patients for, which can further intensify their workload and their time-sensitive tasks like turning, vitals and glucose readings. This mostly affects day-shift workers, particularly first shift, which is already the busiest shift in the hospital. First shift workers in units that have a heavy schedule of tests or therapies will try to get a report from the nurse about the schedule for each patient, or check on the patient's notes at the beginning of the shift.

Patients going for tests must be prepared, depending on the type of test. CNAs cannot take blood samples, but can take urine samples, by providing the patient with a cup, collecting the samples, preparing the cultures and sending the samples to the lab. Preparing for tests outside the unit might include taking vitals, administering an enema, and making sure that the orders for NPO (nil per ora) are adhered to, or removing and safely storing jewelry, removing monitors, checking that IVs are not low and reporting

any that are to the nurse, getting the patient up and ready for transportation, and even helping the transporter if necessary. When the patient returns, monitors are reattached, and CNAs are often rushing around to find a meal for patients, since if they had previously been NPO, food might not have been ordered.

On many units, recording intakes and outputs are important, and CNAs do this either by noting how much patients eat from their meal trays, and asking them how many times they have urinated or had bowel movements that shift (in some units, patients measure their urine output in the bathroom) or by measuring the output in the Foley catheter and observing the amount of water drunk. While CNAs cannot insert catheters, IVs, wound drains, or feeding tubes, they can empty catheters and drains and measure the contents.

Some units have particular challenges, for example dealing with surgical ICU patients who need intensive care and more regular vitals for a few hours post-surgery before being moved into the general population, often on the same unit. Isolation cases also pose particular challenges. There are some specialist airborne isolation rooms with double doors, but general rooms may also contain isolation patients. CNAs must prepare these rooms, and make sure that all the equipment is on hand, and sometimes also prepare the patient, by explaining the procedure. If the patient does not speak English, there are printouts in various languages that the CNA can give to the patient. CNAs working with these patients need to put on and discard gowns every time they enter and exit the room and make sure all equipment is cleaned appropriately or sent out to be sterilized after each use, as well as making sure they practice and even higher standard of hygiene themselves. This adds considerable time to the most routine of tasks.

Rehab and therapy units. Rehab and therapy units are different from other units in that they have a range of other staff who work in and around the units, particularly physical therapists and occupational therapists. The CNAs work closely with them, and both CNAs I interviewed from these kinds of units mentioned that therapists would often help in moving patients and taking them to the therapy rooms, while most nurses would not. In these units, CNAs working on day shift have to work on, and around, the therapy schedules of the patients. The handover includes getting patient assignments, and their schedules, and making sure to have a copy for themselves and the patients. In one unit, patients had four therapy sessions totaling three hours daily, taking place in the morning and early afternoon. In another unit, the extended care facility (ECF) that treated older patients with long-term orthopedic problems, the therapies were not so intensive. Therapies start around 8.30am, so alongside the usual morning tasks of taking vitals and dealing with breakfasts, patients need to be bathed and helped with getting out of bed and getting dressed for their therapy, which usually occurs nearby the unit. This is not only personal care, but can be part of the assessment of patients, as Marta, who is studying to be an RN, explains:

Most of the time we do the sponge baths in the morning. You try to set them up and have them see what's the most that they can do. And then that's also part of what you report off to the nurses. How much they were able to do on their own and how much you helped them (Marta, personal interview, May23, 2013).

In the ECF the occupational therapist would bathe some patients as part of their assessment and therapy. In general, patients may need a lot of gentle persuasion to do the necessary tasks of bathing and getting up, because of the pain they experience, or their fear of falling. But experienced CNAs do their best to encourage patients, often

incrementally, to do as much as they are able.

The morning rush eases up around 10:00am, when most patients are out of their rooms, and CNAs have a chance to make beds and tidy up before their return. They may also help the therapists in taking and collecting patients from the gym or therapy room.

Patients return for lunch, although some eat at tables set up in the gym as part of their speech therapy, so CNAs must make sure that trays go to the right places. After lunch some patients may take a rest in bed or in a chair, but they may have additional therapy to prepare for. The final therapy sessions are at 5:00pm, and after that patients tend to be exhausted, and go back to bed. In the ECF, the pace was more leisurely, and after therapy the patients might ask to be taken to the solarium, or for a walk in the hallway, or just stay in their room.

The work in getting patients out of, or back into bed is physically tiring for CNAs, particularly if patients are heavy or less able to help in the process. If there are two CNAs, they will generally help each other with the work, but if the census is low and there is only one CNA, the Unit Assistant may also pitch in, or the physical therapists may also help with moving their patients, which can form part of their own evaluation of the capabilities of the patient. In the ECF, the physical therapists may also help to transfer patients into and out of bed, since many patients have hip problems that need to be handled with extra care.

Outpatient units. I interviewed four people who worked in outpatient units: two worked in PACU, which was the day surgery unit, and two in wound care, where patients from the hospital and from outside would come in for specialist treatment, including therapy in the hyperbaric oxygen chambers (HBOs).

In wound care, patients spend a few hours on the unit, but come once or twice a week over a few weeks or months. In the case of new patients, the CNA takes their vitals and their weight and some patient history, including who referred them, and how long they have had the wound. They also need to obtain signed consent to take photographs of the wound. These photographs are taken as a baseline, and new pictures taken every month to check on progress. Regular patients are taken to an examination room so the CNA can take vitals, remove the dressings and wash the area around the wound, check for edema and other unusual signs before reporting to the nurses, who will come in and clean and dress the wounds. According to Teddy, an older, male CNA, who was also trained as a Patient Care Technician:

At the wound center, the most incredible thing that—especially most when I see patients healing. When I'm the first person to unwrap the wound. So I have seen most of them previously maybe the week before and I open it and I say, "Oh my God, you are forming some nice granulation tissue, this is getting well" and it gives them joy and happiness, and I'm happy about it that things are working well. Oh, my God. This product we used is really working for you. Your leg is looking much better, your wound is looking much better, there's less maceration, there's less drainage and I said, "Well, this is looking good" and I'm happy about when the patients were happy and then I told the nurse, "Oh my God, I just unwrapped this patient and the wound is really good" (Teddy, personal interview, May 18, 2013).

While CNAs may get to know patients in inpatient units or in wound care, patients on the PACU (the outpatient surgery unit) have much more fleeting contact with CNAs, usually measured in an hour or two. Patients here are ambulatory, and the work of the CNA is in preparing them for surgery by collecting them from the waiting room, welcoming them to the unit, and ushering them to their room. At this stage they collect and mark their belongings, putting them at ease often by explaining what will happen before their surgery, and encouraging them to undress and put on their gowns and socks,

weighing them and taking their vitals, and collecting and copying the required paperwork for the nurses (e.g., medication lists). I interviewed two CNAs from this unit and both stated that they used humor to calm patients who were often very nervous about their procedures:

We're the ones who go out and go get them [from the waiting room]. So we bring them back and once we close the door I always tell them, "Is everyone ready to go? We're going to Alice in Wonderland, we're going to go to the Wizard of Oz", kinda break the ice a little bit because people are a little tense, or . . . emotional. So then, when they come through it's like "Okay, don't worry, we're just going to go to the other side." It's a really sterile environment, everything is white and everyone has the same colors on, and so they come in and it's like, "Where are you taking me? What's going on?" (Ruth, personal interview, November 30, 2012).

When the nurse has finished with the paperwork, the CNA summons the family, who are allowed to come into the unit to be with the patient, although only a few at a time. They also keep the family informed of the schedule, and escort them out to the waiting room when the patient is in surgery. The unit has a production line feel to it, and it is the responsibility of CNAs to keep it moving, while being a reassuring and humanizing presence for patients:

But it's just, we have a time crunch, and I know that's another aspect where I try not to let the patient realize that, okay, we have a time frame to meet, so . . . by this time you need to be laying in the bed, you need to be with an IV, you need to be just ready to go, so that whoever comes in from the OR as the team, then they can just go in and say their spiel and they can just leave. . . . I don't want them to feel like they're on a conveyor belt, and they're in a factory line, . . . I want them to feel like it's a personal experience where, even though I might see, maybe, 40 people in a day, you're the one main focus that I have, he even if it's for five minutes (Ruth, personal interview, November 30, 2012).

When the patient is in recovery, they are responsible for keeping patients comfortable, for example by bringing extra blankets. After recovery they may even be the one who helps them into the car to go home. Unlike other CNAs, their contact is limited both in time

and in intimacy, since their patients need little in the way of personal care.

So far, I have shown how CNAs at Northside Hospital perform the basic care tasks that are the core of the CNA's job description in all healthcare settings. In the next section I show how cross-training extends their versatility within different hospital units. This breaking down of occupational boundaries is one of the principles associated with "lean service" (Brannon, 1996).

Cross-Training and Specialist Training

One unexpected finding was the level of cross-training of CNAs at Northside. While the limited literature on the most recent iteration of team nursing mentions the adoption of flexible teams and cross-training based on "lean production" techniques, (Brannon 2006) the ways this has impacted CNAs have not been studied until now. At Northside, the majority of CNAs are cross-trained, and CNAs are employed under a variety of job titles, each of which has particular responsibilities beyond their basic certification. This reflects an expansion of the role of CNAs to create a more flexible workforce in the absence of LPNs. In effect, it means that CNAs can work flexibly in performing both the core tasks and some more specialized ones, according to their unit specialization. However, the cross-training is provided in-house and is unaccredited, meaning that it is not transferable if CNAs move to another hospital.

Only 29% of workers with the CNA certification have the job title of "Nursing Assistant" (data provided by Northside Hospital) and even these are required to have a CPR certification in addition to the CNA certification (job advertisement for Nursing Assistant, Northside Hospital website). The most common role extension is through cross-training in clerical and reception work, so that CNAs can also work as unit

secretaries, which in the past were dedicated clerical positions. Of the CNAs at Northside, 61%, including most new recruits, have the title Unit Assistant (data provided by Northside Hospital). This title requires the CNA certification, but also includes clerical and reception duties at the unit level, including the paperwork associated with new admissions, discharges and transfers; putting together patient history files and printing wristbands. Some CNAs had previous experience in clerical work, but they also have access to training on the hospital systems, including a short period in the classroom followed by further training on the job. Unit Assistants are rostered for some shifts where they purely do CNA work and others where they have clerical responsibilities. However, even when undertaking front desk duties they are expected to work flexibly and undertake CNA work when they are not busy, for example, answering call lights or assisting other CNAs in turning patients. Of my interviewees, older CNAs and male CNAs were less likely to be trained as Unit Assistants. None of the men I interviewed, or of the CNAs over 55, were Unit Assistants and only one of the older women had any kind of cross-training. Isabella, a 61-year-old veteran CNA, stated that she chose not to train as a Unit Assistant because she did not like dealing with the phones and physicians:

Yeah it was an opportunity . . . but I am really not comfortable answering phones and dealing with doctors and sometimes doctors act so mean and, “Get that for me right away,” or, “You are stupid,” or something, things like that, that I don’t like. I couldn’t handle (Isabella, personal interview, July 18, 2013).

Part-time and recent employees were also less likely to be Unit Assistants, although some of the recent employees were simply waiting to be trained.

Other CNAs have received specialist training that allows them to take on additional roles within particular units. An example of this is the position of Unit

Secretary/Monitor Tech, working in the IMCU and telemetry units. These units are a step down from the ICU, but still have a large proportion of patients that need a high level of care, often with cardiac conditions, and their vital signs are constantly and automatically monitored. Monitor Techs receive in-house training in cardiography and are based at the nurses' station. They work as secretary/receptionists while observing the banks of patient monitors and alerting the RNs when there are problematic readings. Around 5% of the CNAs at Northside have this job title (data provided by Northside Hospital).

A further 5% of CNAs are trained as Scrub Technicians and work in the Obstetrics units, particularly in Labor and Delivery (data provided by Northside Hospital). They are trained to prepare the operating room and pass instruments for surgeries such as C-sections and tubal ligations. Again, this is an extension of their role as CNAs, since they still perform the core tasks of the assistant.

When I visited the ER to try to recruit participants, I was informed that a few CNAs received training as ER Techs, but that most ER Techs were trained paramedics or EMTs (field notes 02/14/2013). This was confirmed by a job advertisement for an on-call ER Tech at Northside Hospital, which stated that candidates should be certified as an EMT or paramedic (Job advertisement for ER Tech, Northside Hospital website). While one person in the recruitment meeting stated he was a CNA, I was unable to arrange an interview with him (field notes 02/14/2013).

CNAs had mixed feelings about the benefits of cross training. Yolanda, a 40-year-old Unit Assistant, also in obstetrics, had resisted training as a Scrub Tech, because she knew they were often called out to assist surgeons, even when rostered as a Unit Assistant:

So I could easily be trained on that, study the instruments and learn to set up and learn to clean it up. . . . There's an option too to do it. But in a way, I think it would be terribly– I can see myself being even more abused if I know the OR too, because . . . they pull you everywhere, and your work is behind. So I thought about it, I'm like, well I'll be more valuable. But in a way, I say, I will be severely abused, as I'm already abused doing both jobs [CNA and Unit Assistant] and then how about if they come in they pull me to the OR? (Yolanda, personal interview, June 13, 2013).

As can be seen from the preceding quotes, one area where cross-trained workers are used extensively is in obstetrics. It would be difficult to describe the work of CNAs in this unit without examining in detail the role of cross-trained Scrub Techs, particularly on the Labor and Delivery unit. The next section focuses on the labor process and division of labor in that single, specialist, department.

Obstetrics. Obstetrics is very different from other departments, primarily because the mothers who go there are not ill, and are usually happy to be there. The obstetrics department is also a locked unit with phone entry and all babies are fitted with alarms by the CNAs for an extra level of security. The hospital is only certified to provide Level I care for this specialty, so difficult or higher-need cases are usually transferred out to a hospital with higher certification for obstetrics. The obstetrics department is divided into two parts: Labor and Delivery, where patients stay until their baby is delivered and for a few hours afterwards, or sometimes for prenatal observation, and Mother and Baby, where patients are transferred until they are discharged, usually after two days, or three days in the case of C-section patients. Each unit has its own set of tasks performed by CNAs. In Labor and Delivery the focus is mostly on the mother. In Mother and Baby the workers take care of two people.

I interviewed three CNAs from obstetrics, all of whom were cross-trained as Unit

Assistants, doing clerical and secretarial work as well as personal care. In addition, two were also trained as Scrub Techs, which means that they can be involved in assisting physicians in surgical procedures in the operating room attached to the unit.

Full-time CNAs in this department work 12 hour shifts with changeover at 7:00am and 7:00pm, usually three per week. Usually there is a Unit Assistant and a Scrub Tech in each unit, although in times of staff shortage there is not always a night-shift Scrub Tech in the Mother and Baby unit. In Labor and Delivery, Scrub Techs who are also Unit Assistants are scheduled for particular duties on particular shifts, i.e., they will either handle the secretarial side, or the patient care/Scrub Tech side. Both roles are filled for every shift, since while C-sections are often scheduled, regular births can happen at any hour, so the night shift can be as busy as the day. Because of this, Scrub Techs in Labor and Delivery are rarely pulled out to the Mother and Baby unit, although the reverse sometimes happens if the workload is high. Unlike many units, the CNAs take report with the RNs at the beginning of their shift, since they take part in the medical procedures of delivery and have particular tasks to schedule within the brief window that patients are in the department. The work of the Unit Assistant has some specialized elements within obstetrics, including preparing folders of general information for patients being discharged, as Sofia, a 32-year-old Unit Assistant describes:

I do all the secretary work for OB registering patients, charging, checking their insurance and pretty much getting the prenatal- where they go and get their prenatal care - and making the charts. So we do – we're cross trained for all of them (Sofia, personal interview, June 13, 2013).

Daphne, who works nights, said that she used quiet periods to put together a stock of discharge folders, whether or not she was the scheduled Unit Assistant for the shift:

I'll put folders together as far as literature information, as far as about the hospital, about, it's a folder that the mom can take home and it talks about the breast-feeding, about . . . installing a car seat, about giving your babies certain medicines and stuff like that. (Daphne, personal interview, July 2, 2013).

In addition to general patient care, Scrub Techs also scrub-in and prepare the OR and the instruments for caesarians and assist the physician by passing the instruments needed. Sofia describes how this takes place:

[A] lot of the C sections are scheduled. so we already know what doctor is doing the C section. And there I am there the whole time handing over all the instruments to the physician, to the surgeon that's doing the C section and we're all on the sterile field and just I'm handing over every single instrument, every single stitch and we count our instruments numerous times. So we're doing that and usually we're in the OR for like maybe an hour and a half and once we are done, once they take the baby and they take the mom, then I have to do the process of cleaning up (Sofia, personal interview, June 13, 2013).

It was a point of pride to Sofia that the RNs were not trained to pass instruments for caesarians, just the Scrub Techs:

We open the OR and we know all the instruments and we pass the instruments to the physician, the nurses don't. That's the only thing. In a vaginal delivery, the nurses do know how to set up the table with the instruments for the vaginal delivery, which are a less amount (Sofia, personal interview, June 13, 2013).

Scrub Techs also prepare the instruments for vaginal delivery, although they may not always be present at the birth- since there is generally only one Scrub Tech on duty, when the unit is busy they may spend the shift going from one room to the next setting out equipment for the birth, then clearing up after the birth. Sofia describes in detail her role in the process of a normal vaginal delivery:

As a CNA and as a Scrub Technician, pretty much if I know that the patient is going to deliver, the nurse will tell me, okay so this patient. So the mom goes through centimeters of opening in her cervix. . . . and the nurse would tell me . . . she's already dilated eight . . . [and] to set up the room. . . . I get the sterile instruments . . . and I set up the sterile field. . . . [O]nce I put on my sterile gloves, I start setting up the table. Just pretty much organizing all the instruments that are going to be used in the delivery. . . . Then I bring a cart which . . . I put . . . outside

the room. . . .

As soon as I'm done with mom, then I . . . put everything where it belongs, either in the biohazard bag, which is anything bloody, anything that has urine or bodily fluids, and then put all the table cloths in the linen basket. And then all my instruments, I put them in that box that I park in the cart that I parked outside the patient's room before. [T]hese babies kind of talk to each other or something- they want to be born at the same time, so I try to organize myself. I park my cart outside so then once I clean up one room, I can either go set up the next room or if I have to clean up another room I'll take the cart and put all my dirty instruments there because that cart needs to be sent to the sterile department (Sofia, personal interview, June 13, 2013).

After delivery, CNAs take the usual vitals, bring snacks to the mothers and urge them to engage in pericare, cleaning of the vaginal area to prevent infections. This is mostly done by the patients themselves, using wipes provided by CNAs, but CNAs also observe the level of bleeding to ensure that healing is taking place.

Once mothers are transferred to the Mother and Baby unit, there are two patients. Babies are kept in the room with the mother at all times unless they are receiving treatment or being tested. During the handover, CNAs find out from the nurses who is likely to be discharged on their shift, and which babies will need hearing tests and circumcisions, so they can plan their work and set up the rooms needed. While only Scrub Techs can assist in C-sections, regular CNAs are able to prepare the sterile instruments and assist the physician in circumcisions.

All babies have hearing screens before they are discharged and this is usually done by CNAs. If there is no CNA on duty at night in the Mother and Baby unit, or the Scrub Tech has been called away to Labor and Delivery, doctors and nurses sometimes do these tests. They take the babies to a quiet room and set up the testing equipment and perform the test. However, CNAs will try to accommodate anxious mothers, like Sofia

did:

For instance there's patients that they're first time moms, they're scared. They don't want to leave their baby out of their sight. So if we do the hearing screen, which . . . needs to be done before they go home, and sometimes if they have a C section, the mom cannot really walk right away. So what I would do to accommodate, to make them feel at ease, as I did it with this particular patient, I brought the machine to do the test in the room. So then she can watch that it's a very non-invasive test for the baby and she can see that . . . I'm not going to hurt your baby. So by the time that it was time for her to go home, she was very pleased, she was very happy that I made her feel so at ease (Sofia, personal interview, June 13, 2013).

Babies need to be calm for optimal results, so CNAs choose a time when they are settled.

If results are inconclusive, then the test must be repeated after a gap of eight hours.

In general, mothers who have had C-sections are less mobile in the first 24 hours than those with vaginal deliveries. They need more help with everything- help to go to the bathroom, with pericare, and with caring for their infants. But other mothers can be demanding, often because they are first-time mothers. CNAs often find themselves teaching mothers how to care for their newborns. Daphne, a CNA who has two children of her own, describes how she deals with these inexperienced new mothers:

I find out that younger moms have a hard time adjusting to being . . . with the new baby, or first time moms, I shouldn't say just younger moms. So I'll go in there, and she's, well, "I keep feeding the baby every hour, and it keeps crying, it keeps fussing and I can't go to sleep and I am really tired and can you watch the baby for me?" Now, in that case they want me to take the baby out of the room and watch the baby . . . by the special care nursery that we have. But most of the time we can't do that because we want to keep the baby with the mom. So I'll take the baby, make sure the baby is all clean, and she goes, "Well, maybe it just needs a good swaddle," and she goes, like, "I don't know how to swaddle, can you tell me how to do it." I go, "Sure, absolutely." So most of the time the father is in the room, so I bring the father over and I show them how to swaddle the baby, and I kind of let him hands-on try . . . so as far as the baby is swaddled and stuff, it's calm. . . . And I say, "So if you still have more trouble at home, just go on YouTube" (Daphne, personal interview, July 2, 2013).

Sofia explains how her routine with mothers and babies has become more efficient over

the years:

I tell them, “Okay, I’m going to be back later to give your baby a bath” and I explain to them how I’m going to give the bath, so they don’t think I’m going to take the baby in the shower. So I know to some people it might be common sense, but to some, they don’t know. It’s their first baby and there’s a lot of young girls or teenagers and they’re having babies, so I try to explain to them everything so they’re not freaking out. I tell them, “Okay, there’s usually a warmer. It’s like a little bed for the baby and it’s very warm.” So I tell them, “I’m going to come back later and I’m going to put a little basin and I’m going to do it right here underneath the warmer.” I’m like, “So the baby can maintain warm because the babies get cold really, really fast.” And then I do the bath where it shouldn’t take more than five minutes. When I first started it would take me longer. But now I think I’m a pro (Sofia, personal interview, June 13, 2013).

Sometimes CNAs feel that patients treat them like a maid, asking them to change the babies’ diapers when they are perfectly able to do it themselves. While CNAs may feel resentment, they make sure to keep a professional and calm demeanor:

I know the patient is fine and they tell me, “Oh! The baby’s diaper is wet. Can you change it?” My response to that, especially first time moms, I tell them- because to me it’s like, okay, you had the baby, you need to learn because you are not taking me home with you, but your baby is going home with you. So I tell them in a nice manner, “Okay, let’s change the diaper together. I will show you so you feel more comfortable. And from now on, you can do it.” I’m like, “Because you can’t take me home with you.” And I kind of, in a jokingly way, tell them the truth, kind of a hint of reality, you have to learn. (Sofia, personal interview, June 13, 2013).

The time that CNAs spend with the mother and baby is also important in terms of observing their interaction- if the mother does not want to interact with her baby, it may be a sign of post-partum depression, and CNAs will let the nurse know if they have any concerns. If the new mother is a teenager, or if there are other issues between the mother and baby, or other family members, Social Services are contacted to follow up on the family. Yolanda describes this part of her duties as a Unit Assistant:

There’s a lot to do before they go home . . . and also especially teenagers, we have to make sure that social service sees them. . . . The doctor puts in the order, or the nurse, and then I page social services and make sure that she comes in and let her

know that there is a consult follow up on that (Yolanda, personal interview, June 13, 2013).

While cross-training provides evidence for the breaking-down of work jurisdictions to increase the flexibility of CNAs at the unit level, the occupational boundaries between RNs and CNAs are rarely breached by CNAs because of the limits of the scope of their practice. However, in some circumstances and settings, RNs may breach the division of labor and undertake tasks usually performed by CNAs, although more commonly RNs enforce the division of labor. The next section looks at the division of labor within the nursing team.

Division of Labor and Occupational Boundaries in the Nursing Team

The big difference that CNAs perceive between their work and that of the nurses is that they are unable to pass out medications or deal with IVs. However, CNAs see that they have much more one-on-one time with the patients and know their temperaments, habits and preferences more than the nurses. Most of them consider their jobs as nursing, which they define as taking care of people, rather than in medical terms. Charles, a young man in college who was planning to leave CNA work in the near future, was clear about his role in the nursing team, even though he was qualified to do more than personal care:

That's my job on the team, it's to help the patient and to relieve the responsibilities of the nurse so he or she can do the medical related things that he or she needs to get done, and I can get this stuff done rather than, I won't say waste our time, that's not fair, that's a belittling of both the patient's needs and my own time, but I can do that. Let me do these jobs so that the nurse can go do his or her things (Charles, personal interview, June 18, 2013).

Role drift and the boundaries between RN and CNA tasks. While there is concern in the literature that the use of auxiliaries can lead to role drift (Benoit and Heitlinger 1998; Castledine 2004; Corbin 2008; Dahle 2003; Davies 1982; Daykin and Clarke 2000;

Edwards 1997; Lee-Treweek 1997; Maben 2008; McKenna et al. 2007; Thomas 1994), there was little evidence at Northside Hospital that CNAs overstepped the boundaries of what they were authorized to do. Both the high proportion of staff nurses to CNAs (two or three to one) and the high nursing standards in the hospital meant that there is little need to encourage CNAs, either explicitly or implicitly (for example, by allowing shortages of more qualified staff) to work outside their certification and training. Furthermore, there is a much brighter line between the limits of what CNAs are authorized to do and the work of RNs, unlike the situation where LPNs are working alongside RNs.

I was told about one example where a CNA was put in a difficult situation by an RN who seemed to act maliciously and had a bad reputation among staff. According to Yolanda, she was instructed to collect some medication from the pharmacy, even though it could have been sent up via the pneumatic tube system.

I was very upset in one particular nurse because . . . she put me in the position that she should have not put me. She sent me to get a narcotic and I felt very bad. . . . I didn't know it was a narcotic until later on the pharmacist says, "Are you a nurse because it's a narcotic?" I'm like, "No, I'm not a nurse," but they gave it to me anyway. And I said, "I can't. If I can I'll just talk to the nurse." I don't want to do something that's not my place because usually a narcotic, a nurse has to sign for it or they send it up with the tube station with the code. And I felt like she's very malicious and I felt like she tried to set me up. . . . She's a nurse that always tries to humiliate me and it hurts so bad, because actually she was charge nurse and they demoted her because of the fact that she would abuse staff (Yolanda, personal interview, June 13, 2013).

Even CNAs who were in college for nursing or other healthcare studies did not work outside their authority as CNAs. As Charles stated:

Low BPs, I have the education and training to know how to respond to that in a medical context, but my job as a CNA is, "Let me go get the nurse." I'll go let the nurse know, they come in, evaluate, often repeat whatever procedural I just did,

often to get the same result, and then it's, "Okay, I'll call the resident." So it goes up the chain of command (Charles, personal interview, June 18, 2013).

Elena, who at age 30 has already worked at four different hospitals, explained that individual hospitals provided different kinds of cross-training, but even if CNAs had training and experience in procedures, because it wasn't certified, it wasn't transferable, and each hospital had its own rules:

Another hospital I worked in, the CNAs were trained to pull out the Foleys, to pull out the IVs, and we also drew the blood, like for the labs. . . . I mean the hospital will train you themselves for that, and they're accountable for it, but here, . . . at this hospital I do not fix that— that's all on the nurses (Elena, personal interview, December 3, 2012).

Answering call lights: When do CNAs call in the nurse? One of the core tasks of CNAs is answering patient call-lights, meaning that they act as gatekeepers for the RNs, deciding whether they can deal with the patient query themselves or if they should call in the nurse. The division of labor is not always straightforward, and discussion with CNAs about their decision-making process was informative in illuminating the boundaries between the scope of practice of CNAs and RNs. Charles explained the kinds of judgments CNAs might make based on the context of different requests:

You have a headache? Let me give you a cool wash cloth for your forehead and to let the nurse know maybe it's time for medication. "I have pain." Well, can I physically readjust you in the bed and make you more comfortable, physical interventions or is this a medication request? "I need to use the toilet." Well, does that mean you can turn yourself and I'll put a bedpan under you? Are you confused and you don't remember you have a Foley catheter in and I need to explain that, so you can release your urine and it will flow in the bag? Do you really want to get up and use the bathroom for the first time even though you came out of surgery two hours ago? Okay let me get the second CNA because I know that- or I need the nurse in here. So, this is some of work CNAs actually do. Good to use their brain, which is nice. It's the judgment call, again, it's what the actual requested entails. "I'm thirsty," although this patient is NPO, "You can't drink anything tonight, but maybe I can get you some ice chips, let me check with the nurse." Or "I'm thirsty." "Well, let me go get more water, no problem." (Charles, personal interview, June 18, 2013).

Some patients may call for medication constantly, either because they are in pain, or because they have an addiction. Even though CNAs know that it is too soon for the patient to receive medication, they are required to answer every call light and pass on the information to the nurse, and possibly go back to the patient to explain when they can next have their meds.

CNAs taking initiative. While CNAs do not normally breach the division of labor by doing tasks that are reserved for RNs, in emergencies they will take necessary action, particularly regarding CPR. In the case of emergencies, there is an alarm in the room that summons staff for a “code blue.” Protocol varies from unit to unit, with some CNAs pressing the alarm themselves, while others stay in the room and call for a nurse, who will then declare the code blue. Since all CNAs are trained in CPR, they may either start it immediately, or act as runner for a nurse. For example, Elena was helping to transport a patient when he went into cardiac arrest:

Sometimes you can't wait for the nurse to come in, you gotta know what you're doing. So, yeah, he's having, um, cardiac arrest. Sometimes it's a matter of minutes that matter, you know. And he hit the button, the transporter, we both knew what to do and went straight in to it, you know. And right when the proper people come in, the respiratory doctors and nurses, I'll stand back, you know, cause they have more training than what I do (Elena, personal interview, December 3, 2012).

Experienced CNAs often know what actions are likely to be taken in common situations, and will take steps to prepare for them. For example, if they see that a patient is unresponsive, they would call the nurse in immediately, and follow behind her with the BP machine, to be ready. Or if they were concerned about a patient, they would call in the nurse and preemptively take a set of vitals or glucose readings to show the nurse. In the case of less time-sensitive situations, like skin breakdowns or soreness, CNAs will

generally apply some cream and report it to the nurse for later inspection.

Some experienced CNAs anticipate instructions that nurses, or even surgeons, are likely to give. Ruth, who has worked in the day surgery unit for a year while finishing her baccalaureate, had learned what individual physicians like, for example, particular kinds of stockings for post-surgical care. She made sure to include them on the chart so they would be billed:

I don't know if every nursing assistant does it, but I know for myself I do. I kinda skim through the chart to look at what kind of procedure are they having? Who's the physician? What that physician likes, because there are certain things that they prefer, and they want their patients to be prepped a certain way. So I'll assist on helping to make sure that that patient has certain items, so that when the physician comes we don't have to worry about it (Ruth, personal interview, November 30, 2012).

CNAs and RNs working together on tasks. CNAs and RNs don't always work separately; some tasks are done jointly. In some units this includes the body check which is done on admission. CNAs are generally responsible for taking vitals, weight, and often some patient history, as well as helping the patient with undressing and gowning, and labeling and storing their personal items. CNAs use medicated wipes to clean newly-admitted patients, to avoid contamination from other units or from outside, and will report any skin breakdown or wounds they observe to the nurse. But in many units the nurse and CNA will clean the patient and look for these problems together, taking photographs and measuring wounds as a baseline for future comparison.

This kind of collaboration can be an opportunity for CNAs to learn, but this seems to depend at least in part on the attitude of both the RN and the CNA. For example, it may depend on whether the CNA asks questions and whether the RN is willing to answer them. Luciana, a 51 year old CNA with 15 years' experience explained how she learned

both experientially and from RNs:

They tell you, “Luciana, the blood pressure goes up, it goes down,” or, “They’re sweaty cause their sugar’s down,” or this and this and that, but, oh my God, you have to be alert. . . . Day by day, different sickness, because we’re seeing every day different things. This is how we’re learning. Those patients are teaching us . . . because, you know, nobody has the time to come and tell me. But if I have questions, the nurses are there, my nurses, my good nurses explain everything. That’s what I have, you know. I can go with them and, “What is this? What is that?” Or they can come, “Luciana, you know, do this or do that and this is what they have, or, you know, it’s because-” It’s that communication (Luciana, personal interview, February 18, 2013).

Alex was fascinated with wounds and found she was comfortable with even extreme wounds that other CNAs were revolted by. She developed a good relationship with the specialist wound care nurse:

When I was thinking about going into wound care, [the wound care nurse] actually told the manager that I was really good, but the floor would be losing somebody who was really good at skin care, because I was always interested in things that she had to show. There was always this new stuff that she would tell me about, and she was actually really impressed with the work that I had done, such as turning the patients or just being smart about it (Alex, personal interview, January 15, 2013).

RNs breaching the division of labor. Sometimes the division of labor may be breached by RNs. For example, if there is only one CNA available and two people are needed to safely turn a patient (which is common on orthopedic wards and the units with large proportions of complete patients, or if patients are heavy) the patient’s RN will step in. In the IMCU, nurses and CNAs work closely together, particularly during the night shift. Nurses on this unit have a lower caseload, usually only 3 patients, so are more likely to do hands-on care with their patients, including helping them with toileting and bathing, and turning them, often with a CNA. Wound care is much more efficient when combined with bathing and cleaning, and CNAs and RNs often perform this in tandem. If the CNA notices that a dressing is soiled while cleaning a patient, she might suggest to

the RN that she could come in and change the dressing during the bathing process. If the RN waits until after the patient has been bathed, it means unnecessary duplication of bathing and cleaning tasks.

RNs enforcing the division of labor. In most units, CNAs are expected to do all the bathing and turning themselves, either individually or in pairs. It was a stated source of frustration that RNs would not help the CNAs even if they were under pressure and understaffed, or would even berate them for falling behind in their work. This was particularly problematic when there were agency nurses on the unit. Agency nurses are contract nurses from outside agencies that hospitals use to cover for staff absences or shortages. Since they have little investment in a particular unit, agency nurses are often perceived as lazy by CNAs, who report that they expect the CNAs to do all the work. In some cases, CNAs report that contract nurses have asked the CNAs about their patients in order to write their shift report.

More generally, hospital RNs often enforce the division of labor by searching out CNAs and interrupting their routine work to get them to answer a call light or to fetch a glass of water or urinal for a patient. CNAs report that RNs would spend more time in seeking out the CNA that it would take them to do the task themselves. This was the most common complaint by CNAs:

[Nurses] come in while we're giving a bath or while we're cleaning, or doing something that takes up some time, and they'll literally spend a half hour looking for us for a cup of water for the patient or putting a telemetry box. It's not . . . that we mind, . . . but if I'm in the middle of something . . . it's kind of common sense, you know; if you took that long to find us, you could have gotten that done. So it gets frustrating sometimes (Melanie, personal interview, May 30, 2013).

Some CNAs are pretty assertive in letting nurses know that they are busy, for example,

Sandy, a CNA who was nearing retirement and had a “no-nonsense” approach:

A lot of times they’ll ask me to get a urinal and they’re standing right there, BY the urinal. . . . But I don’t say anything about that. I just tell them the same thing. I say, “Well, what does he want?” “He needs a urinal.” I say, “Well, if you can’t wait, there’s one right there at the bottom of the drawer, otherwise I’ll be back later” (Sandy, personal interview, February 14, 2013).

If RNs spend time searching for a CNA to deal with toileting, rather than dealing with it themselves, it can lead to more work for CNAs. Delays in attending to the patient’s needs can lead to defecation or urination in the bed, meaning that CNAs must then clean up the patient and change the sheets.

When there are conflicts between nurses and CNAs, either on an individual level or about the division of labor generally, it is usually the Unit Manager (a nurse) who intervenes to resolve the situation. All the CNAs spoke highly of their Unit Managers and felt free to approach them with issues concerning their work, conflicts with individual nurses, or even personal issues. Unit Managers would sometimes call team meetings to resolve broader issues and establish rules, or even to resolve individual conflicts with a broader set of guidelines about how the team should work. Even though Unit Managers are all RNs, their responsibility is clearly to involve the whole team in the smooth running of the unit. In one case, Melanie, a young CNA in her first job, had persistent problems with a particular nurse who she thought was lazy and who would even pull CNAs out of their break times to answer routine call lights. Melanie had complained up the chain of command to the Unit Manager, who was sympathetic, and who had received complaints from other staff. But the nurse’s behavior did not change. Melanie states:

I was really frustrated, I was behind on all of my stuff and this nurse had been on two breaks- . . . she was just taking her time with everything. . . . She came and got me from lunch and asked me to get my patient, order something from the

kitchen, which anyone can do. Really, anyone, including that nurse (Melanie, personal interview, May 30, 2013).

One of the most common complaints from CNAs was that some RNs do not give them respect for the work that they do, particularly as their relationships with, and observations of, patients can make a difference to the work of RNs. Sometimes CNAs have to spend a long time with an individual patient cleaning them up. Since they cannot leave patients in the middle of this, other call-lights go unanswered. CNAs may let the unit secretary know, and they may pick up the slack, but sometimes the CNAs appear to be missing for long periods, and a nurse will criticize them for neglecting their other work. CNAs may also become the targets for nurses who are stressed or under pressure or just have a bad attitude, particularly if they have fallen behind. Graciela gives an example:

[A nurse] was trying to talk to me in the patient's room and trying to tell me why I hadn't done this stuff yet that was important. And I told her not to argue with me in front of a patient- if she wants to talk to me we could do it at the nurse's station. And I said that twice to her. The fact that I said it twice was awful enough (Graciela, personal interview, July 18, 2013).

Being disrespected or "dressed-down" by nurses (particularly in public) is seen as galling for all CNAs, who are conscious of their important role in patient care, even if they do not have the education or certification of the RNs. Yolanda explains that she maintains her dignity in the face of disrespect from nurses:

I would tell her even if you have a higher education than me, it doesn't mean that you are worth more than me. I'm like, we are equal, and I work very hard too, and I have my family too. So I think the value of a person is how they treat others and their morals. That's the true value (Yolanda, personal interview, June 13, 2013).

Luciana also felt that the work of the CNA was undervalued in the hospital, particularly since they are often the first on the scene when patients have difficulties:

They don't realize . . . the responsibility that we have, they have no idea. If we was just there to clean and everything, guess what? I'm the one that saw when the patient was going to choke to death, where he was gonna fall, or he was acting crazy, and this and this and that. If it wasn't for me, God knows how many lawsuits they would've had, or how many of this or this and that. They don't realize what a CNA does. They have no idea. Up to now, they don't know (Luciana, personal interview, February 18, 2013).

While CNAs understand their role within the nursing team, many of them commented on the importance of teamwork, not only in the sense of the division of labor within the team, but also in working together to support each other in the labor process. There was resentment when RNs stuck rigidly to the established division of labor, even when it was inefficient and caused extra work for the CNAs. The refusal of some RNs to do what are considered menial tasks was a particular source of friction.

Conclusions

The removal of LPNs from nursing care at Northside Hospital is at the leading edge of the national trend in deployment of LPNs. Former team-nursing arrangements which included LPNs were unpopular with RNs because of the difficulties with substitution, social closure and role drift (Brannon 1996; Dahle 2003). The scope of practice for RNs and CNAs is very different compared to that of RNs and LPNs, and there is no risk of substitution of RNs by CNAs, something which frequently happened in the previous iteration of team nursing after the Second World War. The removal of LPNs resolves some of the issues that RNs had with team nursing. It has also aided their struggle to gain professional status, which was difficult because of the issues of social closure that were highlighted by the ambiguous role of LPNs as both nurses who could perform tasks like passing meds, and as auxiliaries under the supervision of RNs.

The bifurcation of the nursing team at Northside, with highly-qualified graduate

nurses with BSNs versus CNAs who have minimal certification means that the occupational boundaries between nurses and auxiliaries are strengthened. The division of labor between RNs and CNAs remains clear and relatively unproblematic (at least, from the viewpoint of RNs), and can be seen as a reflection of the Taylorist concept of the division of mental and manual labor. However, the widespread popularity of more modern ideas about efficiency improvements of the labor process, particularly those of lean production and total quality improvement, have not left the medical industry untouched. The institutional requirement for an efficient workforce requires that workers become flexible through the breakdown of occupational boundaries. This has been achieved through the cross-training of many CNAs at Northside Hospital.

This has not impinged on the labor process of nurses, but has replaced or reduced the need for other auxiliary and technical workers within the hospital. For example, Unit Assistants have replaced dedicated workers who formerly performed clerical, secretarial and reception work but, unlike the clerical workers, Unit Assistants can step in and do patient care as needed. In the case of Scrub Techs, the specialist training of CNAs in preparations for a limited range of surgeries performed in the obstetrics department removes the need for operating room technicians, who are trained for a much wider variety of procedures. These surgical techs earn around twice the pay of CNAs (Bureau of Labor Statistics 2014), so cross-training Scrub Techs is a cost-saving to the institution, while ensuring that there are sufficient CNAs on the unit to perform the routine personal care of patients. While the experience that CNAs gain in a wider range of tasks within the hospital through cross-training can be seen as job enrichment, the fact that the in-house training is not accredited means that it will not be transferrable to other hospitals if the

worker moves. As Elena discussed earlier, her training in another hospital to draw blood and to pull out Foleys and IVs did not mean that she could perform those tasks when she moved to Northside Hospital (Elena, personal interview, December 3, 2012).

Although CNAs and RNs mostly work independently at their own tasks, there is some collaborative working at Northside Hospital particularly in high care units like the IMCU, where individual RNs have lower patient numbers. But the CNAs I interviewed complained that many nurses would not help them in their work when they were busy and the nurses were not. This unwillingness to do menial tasks, even in the interests of efficiency and teamwork is seen as a power play by many CNAs. For example, George felt that many RNs did not want to do the “dirty work” of patient care once they had qualified:

The basic needs is what we do. I mean, nurses are fully capable of doing that but as soon as they get that paper, as soon as they graduate, like especially the ones that are on my floor, they pretend they can't do it anymore, like a majority of them pretend like it's, “Oh, my god. I have a CNA, they can do it. They can do all that stuff.” All that dirty stuff. And it sounds like they're just there to pass meds and that's it (George, personal interview, June 4, 2013).

While the main role of CNAs is to provide personal care and comfort work to patients, their work often extends beyond this to medical and clerical tasks, like the taking and charting of vital signs and blood glucose. In addition, the CNA is usually the first person to respond to a patient's call light, or to observe difficulties with patients while they are performing personal care tasks, so CNAs are the gatekeepers for the RNs, and act as a conduit for information between the patient and the RN. The basic medical knowledge they acquire through their experience working in an acute hospital helps them in the everyday judgment calls. Through experience, CNAs begin to know when they should

call in the nurse, rather than deal with a situation themselves. They also develop strategies for dealing with particular situations, for example, non-medical interventions that can aid patients in pain. Knowing when to escalate an issue with the nurse is an important efficiency issue within the units. By taking initiative, for example by taking a new set of vital signs that they know will be required if they call in the nurse, or by suggesting that the nurse deals with wound care while the CNA is bathing a patient, or even by suggesting non-medical methods of pain alleviation, the CNA can save time spent by the RN in dealing with routine patient care. The importance of CNAs to the grassroots work of hospital nursing is also suggested by the way in which Unit Managers are willing to intervene when CNAs have issues with nurses, or with the workload presented by the division of labor on the unit.

The cross-training of CNAs extends their work even further. Over 60% of CNAs at Northside have additional training, but this is an extension of their roles as CNAs and does not violate the occupational boundaries between RNs. It also increases flexibility, for example, by using cross-trained CNAs as Unit Assistants/secretaries, the hospital is able to ensure that even when they are on shift as a Unit Assistant, they can pick up the slack in personal care, unlike previous dedicated clerical workers. In the case of the Scrub Techs who work in the Obstetrics department, they are effectively working as operating room assistants, although their training is limited to only a few kinds of procedures. Again, they still do the personal care work associated with the CNA role.

While some of the training extends to the use of specialist technology, for example, the telemetry equipment, the CNAs must simply pass on patient information to RNs, since they are not trained or certified to carry out any invasive procedures or pass

medications, unlike LPNs. In fact, the cross-training of CNAs satisfies the institutional need for a flexible and cost-effective workforce, while simultaneously strengthening the occupational boundaries between RNs and nursing auxiliaries that had previously been violated by LPNs. The advantage to the hospital is that they keep their highly-qualified RN staff, who supervise and manage patient nursing care, while having a more flexible and enhanced body of nursing assistants who can provide the first line of defense. While the cross-training does not greatly improve the status or the pay of CNAs, it seems to be the cost of gaining and keeping their employment in a difficult economy, and in an institution that has high standards for nursing care. The CNAs who are cross-trained receive a small financial benefit from the training, but also take pride in the additional tasks they can do, and may even use the experience as a springboard to other, accredited, training, a theme I discuss in more detail in Chapter Five.

While CNAs often work quite independently in completing their scheduled tasks, they are aware that the supervising RN is ultimately responsible for their work. Graciela had graduated from her RN course the week I interviewed her, and was in the waiting period to receive her license. As such, she probably had a particularly clear understanding of the liability of RNs for patient care:

As a CNA you don't have the license, your professional career isn't on the line when you are trying to take care of your patient as when you're an RN. And I try to tell the CNAs that that when they get frustrated. I'm like, "Really . . . this is what your nurse should be taking care of." But yes, we're a part of that but ultimately it comes down on her shoulders (Graciela, personal interview, July 18, 2013).

In Chapter Three I focused on the labor process of CNAs and the division of labor within the nursing team at Northside Hospital. In Chapter Four I discuss the role of the

CNA as a care worker, including how CNAs conceptualize care. Another way of conceiving this is to say that Chapter Three dealt with the instrumental work of the CNA, while the focus in Chapter Four is on the affective aspects of their work. I also look at the issue of emotional labor and emotion work; CNAs see the emotional aspects of caring as important to their work, but this should be distinguished from the institutional requirement to exhibit particular emotions in order to elicit corresponding emotions in patients. Previous scholarship on workers who perform personal care has suggested that there is an opposition between professionalism and emotional care (Cancian 2000; Chambliss 1996; Misra 2003, Stone 2000), while CNAs see emotional care as an essential aspect of good patient care.

CHAPTER FOUR

“THE ANGEL AT THE BEDSIDE”: AFFECTIVE CARE AND EMOTION WORK OF HOSPITAL CNAS

Care work exists at the intersection of a series of dichotomous, and gendered, concepts. These include care as both a practice (caring for) and a disposition (caring about) (Abel and Nelson 1990; Cancian and Olicker 2000; Tronto 1993). As Abel and Nelson write:

[C]aregiving is an activity encompassing both instrumental tasks and affective relations. Despite the classic Parsonian distinction between these two modes of behavior, caregivers are expected to provide love as well as labor (1990:4).

However, the industrialization of care has generally been based on the separation of mental and manual labor (Tronto 1993). The conceptual stage of “caring about” includes a general assessment of needs and how they should be met (Tronto 1993), and in hospitals this task belongs to senior management policy makers, who also consider available resources and efficient use of funds. “Taking care of” encompasses the direct managerial level of the care process, including the detailed, individual assessment of need and the appropriate response, according to bureaucratic rules about how care should be provided institutionally (Tronto 1993). In a hospital setting, doctors and nurse managers organize this level of care. The job of nursing assistants encompasses the “care-giving” phase, the physical delivery of care (Tronto 1993). This is generally low-status and low paid work, performed by women, people of color and the working class, under

close supervision or to detailed schedules (Tronto 1993). Since RNs are responsible for patient care delivered by CNAs, the work of CNAs is rendered invisible by the bureaucratic logic that two jobs at different hierarchical levels cannot be responsible for the same outcome (Acker 1990). The literature on hospital nursing demonstrates this; nursing assistants are missing or barely mentioned in most accounts of nursing care.

Debates about Emotional Labor and Emotion Work

In her study of the sociology of emotions, Hochschild (1983) draws on Freud, symbolic interactionism and Marx to argue that there is a mediation between feelings, which are pre-action, and the actions and performance displays that ensue. We manage our emotions by reference to “feeling rules” which are learned, and which are a set of moral stances and scripts which prescribe expectations, rights and obligations that other people have to our feelings, and that we have to other people’s feelings. These rules are not fixed, but vary according to culture, gender, class and social role. We are judged in our interactions according to the appropriateness of our emotional displays. A great deal of emotion work is carried out within families, where the social roles and bonds are greatest, and where ambiguities may also be great. For example, there may be a feeling of relief when a loved one dies because of the heavy toll that caring for them might have taken. This is generally considered inappropriate, and the caregiver may also feel guilt for those feelings, and manage emotions to produce an “appropriate” expression of grief to observers (Hochschild 1983).

Hochschild (1983) makes a distinction between emotion work and emotional labor by drawing on Marx’s (1978:152-3) contradiction between use value, which she applies to emotion work in the private sphere, and exchange value, which inheres in the

commodity form and which Hochschild applies to emotional labor, the commodity form of emotion work (Hochschild 1983:7). It is assumed that in interactive service work the quality of the interaction is part of the service, even if this is implicit, and this will include an element of emotional labor (Hochschild 1983; Wharton 1993). These kinds of workers are selling not only their labor power, but their attitude and emotions, and they are hired or trained to manage their feelings in order to create a corresponding feeling in the customer, whether it is feeling comfortable and important, as in the air traveler served by the flight attendant, or humiliated, as in the debtor contacted by a bill collector, or even frightened, as in the bouncer and the club customer (Hochschild 1983; Leidner 1999).

In jobs that involve only ephemeral encounters, for example, fast food work or retail sales, surface acting is all that is required to speed up smooth interaction. In other jobs which involve persuasion, or where there is a longer relationship, workers must believe in what they are doing by taking on the employers' required viewpoint, even if that requires modifying their emotions to fit. Interactions are frequently routinized by use of scripts which give the employer greater power in standardizing the work, but may also allow workers to minimize their emotional involvement while giving them more control over the interaction. However, scripting is often used even for jobs that involve deep acting, and part of this acting may be invoked in the need to disguise the scripted nature of the interaction to make it seem authentic to the customer (Hochschild 1983; Leidner 1993; Leidner 1999).

Emotional labor in interactive service work challenges the idea of the separation between conception and execution of the task that characterizes capitalist production,

since the worker must perform emotional labor both on their customers and on themselves, keeping them in line with what management has deemed is appropriate. This area itself is gendered; while jobs with a significant portion of emotional labor are dominated by women, this is mostly of the caring-for, or positive, kind. Where men use emotional labor, it is often for the purpose of coercion, for example, in security work, or police interrogation, or in sales (Hochschild 1983; Leidner 1999; Steinberg and Figart 1999b). However, while the concept of emotional labor is rooted in interaction, it is one-sided, without a recognition that the other partner in the interaction may also be eliciting emotions in the worker that do not fit the criteria of emotional labor, for example, in the friendly relationships between waiters or bartenders and “regulars”, or between patients and care staff (Theodosius 2006).

The self-regulation of emotions may affect worker’s ability to express authentic emotions outside work, since this kind of control operates at the bodily level, and in ways that may be permanent, rather than something that can be switched off when no longer being paid for (Hochschild 1983; Smith 1994). Emotional laborers who have less autonomy tend to suffer more from feelings of inauthenticity and depression (Erickson and Wharton 1997), but other research suggests that emotional labor has a positive role in job satisfaction, particularly for women, and particularly in jobs with more autonomy. This may be due to selection for the kind of people who are already empathetic and enjoy interaction with the public (Wharton 1993). If this component is seen as an intrinsic benefit of interactive service work, it may be used as a justification for the lower wages paid, as these workers suffer a wage penalty, compared with jobs requiring similar levels of education, skill and working conditions (England 2005).

Emotion Work and Emotional Labor in Healthcare Settings

There is no literature that specifically looks at the question of emotional labor and caring among hospital-based CNAs, but there is some relevant discussion about nursing and emotional labor, and about CNAs in residential and nursing homes.

While on paper the nursing assistant's job is defined by a series of physical care-giving tasks, the reproductive labor, there is also the expectation (at least on the part of patients and their families) that they will care *about* patients in an emotional sense, the interpersonal and affective work of caring (Duffy 2005; Lopez 2006; Rakovski and Price-Glynn 2010). However, this emotion work should be distinguished from 'emotional labor' which involves the requirement to display organizationally sanctioned emotions on the job in order to elicit particular kinds of emotions from patients or customers. This emotional labor might include, for example, dealing in a prescribed way with patient's families who are complaining or making unreasonable demands (Bullock and Waugh 2004; Hochschild 1983). Dealing with emotional situations at work (both emotional labor and emotion work) can make it difficult to be nurturing at home, particularly for front-line workers like CNAs who are less likely than nurses to have offices or places to retreat, either at work or at home (Bullock and Waugh 2004). This highlights another conflict inherent in paid care giving, in that CNAs are ordered to feel emotions that we expect to be spontaneous (Chambliss 1996; Hochschild 1983; Reverby 1987). The public discomfort in putting a price on emotion, and the expectation of an altruistic motivation on the part of care workers, means that care work is seen as having intrinsic rewards that conflict with the extrinsic reward of pay (England 2005; England, Budig and Folbre 2002; Nelson 1999).

It has been argued that commodification of emotion alienates workers from their authentic emotions (Hochschild 1983). However, it is clear that many caregivers place great value on the affective component of their work, and that such jobs do not in themselves lead to lower job satisfaction, although the combination of emotional labor and lack of autonomy is associated with increased stress levels (Rakovski and Price-Glynn 2010; Tronto 1993; Wharton 1999). Nursing assistants in nursing homes value competence in reproductive care, but gain satisfaction from the emotion work, both for the interactional elements, and because of the value that patients and family place on it (Rakovski and Price-Glynn 2010). They seek legitimacy both as caregivers and as workers, and resist trading recognition (status) for redistribution (pay) and vice versa (Folbre 1995; Fraser 1995; Macdonald and Merrill 2002). Caregivers themselves have a clear image of what constitutes good care but their assessment of what is necessary is often in direct conflict both with professional norms of care giving and constraints of time and money; high staff turnover and chronic understaffing in nursing homes often leads management to prioritize the reproductive work at the expense of caring interactions. However, many care workers find ways to provide personalized care by ignoring the bureaucratic mandate of “professional standards” although the emotional demands of providing this “under the table” care may cause even greater stress (Misra 2003; Rakovski and Price-Glynn 2010; Stone 2000). Furthermore, employers may use care workers’ attachment to patients by implementing cost-cutting strategies so that caregivers will intensify their work rather than cut down on care provision (England, Budig and Folbre 2002).

It is notable that the formal training of nursing assistants pays little attention to

either the nurturant and interpersonal skills or the practical tasks of caring, because it is assumed that the trainees have a history of family caring (which is itself predicated on the assumption that trainees are women). The narrow focus on biology, technical knowledge and professional practice makes the skills that comprise the major part of the CNAs work invisible, or reduces them to a checklist of tasks (Cancian and Oliker 2000; Diamond 1992; Solomon 2008). The medical model of care means that, even for nursing assistants, tasks like regular taking and recording of vital signs and the completion of paperwork required by state regulations are prioritized over comfort work, sentimental work and emotion work (Cancian and Oliker 2000; Strauss 1997).

Training and professional norms of hospital care caution against getting too attached to patients, and the routinization of hospital work serves to protect staff from stress, by depersonalizing individual patients and transforming them into ‘cases’ (Chambliss 1996). However, this is difficult for CNAs, who are the gatekeepers between patient and institution, the first point of call and most regular daily contact. Nursing assistants use talking and listening, as well as non-verbal communication, to build trust with patients and make them comfortable with the intimate care they must perform and this can make it difficult for workers to distance themselves from patients, even if they have no formal responsibility for ethical and professional judgments about care (Stone 2000). Only physical and medical information is usually charted, making emotional care invisible to the institution, even though it can facilitate the provision of physical care (Cancian and Oliker 2000; Stone 2000). Furthermore, professional norms proscribe ‘unnecessary’ touching, for example, physically comforting patients, and workers who develop caring relationships with patients may feel ambivalent, seeing themselves as

professionally incompetent (Stone 2000). This regulation of emotions can itself be seen as a form of emotional labor. However, time is rationed and scheduled most in settings where care is most closely supervised, like hospitals. Nursing assistants are often reprimanded if responding to the emotional and social needs of patients slows down physical aspects of care and paperwork, and supervisors often have negative evaluations of workers who are seen as the most effective by patients (Cancian and Oliker 2000; Diamond 1992). It may be that low-paid caring work becomes less appealing to workers absent the intrinsic rewards (Misra 2003).

Caregiving and Pastoral Power

Emotional labor can be seen as the exercise of power over patients or customers, since its purpose is to persuade them to feel and act in a particular way. However there are other ways of conceptualizing the power that nursing assistants have over patients, even though their status and authority in hospitals is limited. This power arises from their personal care work, surveillance and individual knowledge of patients, embodying Foucault's concept of "pastoral power" (Foucault 1988; Lee-Treweek 1996). This kind of power is in opposition to forms of power based on reason and bureaucracy (Foucault 1988), for example, the bureaucratic power of hospital management and hierarchy. Instead, it is based on the ideal of the shepherd assuming responsibility for meeting the individual physical and emotional needs of each member of his flock, and acting in their best interests (Foucault 1988). In health care settings, this nurturant power is based on the provision or denial of physical and emotional need, which is seen as a particularly feminized form of power (Lee-Treweek 1996). Pastoral power is not exerted through force or aggression, but through kindness, nurturance and knowledge, although

persuasion may at times become coercion (Lee-Treweek 1996).

Boundary Work

There is evidence that care workers in residential and nursing homes use “boundary work” (Thorne 1993) to classify residents into two different groups. The “lovelies,” are compliant and allow staff access into their rooms and their feelings. The “disliked” are seen as demanding and resist the total access and infantilization preferred by some front-line care staff. “Disliked” is more often applied to women, since men are expected to be more demanding. Their unwillingness to participate makes staff feel that they were merely housekeepers. They respond by withdrawing emotional support and by doing merely the reproductive tasks for those residents, and find any displays of emotion in them to be inauthentic or fleeting (Lee-Treweek 1996). In these kinds of institutions, where aides often make up the majority of staff, affective care may be elective and selective, and care assistants use common categorizations of patients to decide who will receive the ‘gold standard’ of care, defined as both instrumental and affective, and who will get just the instrumental (Berdes and Eckert 2007; Lee-Treweek 1996).

Åkerström (2000) discusses a different kind of boundary work by showing how nursing assistants minimize physical assaults by patients by refusing to “frame” them as “violence” (Goffman [1974] 1986). In one survey, 70% of nursing home or mental home auxiliaries who were asked whether they had been hit, punched or scratched, sometimes or regularly, responded affirmatively. However, in other research that asked about the incidence of “violence,” a much lower rate overall was reported. Rationales for refusing to label physical assaults as violence took four forms. First, since the patients were old and frail, their physical assaults did not meet the threshold of violence. Second, violence

was seen as a normal reaction to the infringements of integrity that were a normal part of care. Third, it was stated that it was not violence, because it was not directed at the worker personally, that they were simply the surrogate or proximate objects of aggression that arose out of fear of death, homesickness or lifelong tendencies. Finally, the workers typically used humor in recounting stories of aggression in order to establish their competence in dealing with such behavior (Åkerström 2000; Berdes and Eckert 2007).

Family Metaphors for Care among CNAs

It is common for aides in nursing homes and home care settings to use family metaphors for care, and even to achieve the status of “fictive kin” to the care recipients (Berdes and Eckert 2007; Parks 2003; Stone 2000). While this is to be expected in these settings, where relationships of care are built up over a long period of time, CNAs in hospital settings also use family metaphors, or more accurately, similes of care, saying that they would like to give patients the kind of care they would want for their own family member. This is held up as the “gold standard” of care (Berdes and Eckert 2007; Stone 2000), drawing on the experience that many CNAs had of caring within their own families. This kind of ideal care combines the instrumental, task-based work of the CNA with the affective, sentimental work of listening and comforting, often simultaneously; the caring for and the caring about phases of care (Tronto 1993). In fact, affective care can be seen as the foundation of good care, because it motivates workers to provide good reproductive and technical care to all residents, in an occupation where the work is hard and the extrinsic motivators are lacking (Åkerström 2000).

Findings

While the literature on care work in residential and nursing homes suggests some

avenues for investigation, there are crucial differences in hospitals that affect the relationships between CNAs and patients. First, unlike residential and nursing homes, patients are in hospital because of acute medical issues and personal care is subsidiary to treatment. Second, patients spend only short periods in hospital, so relationships are more fleeting and do not achieve the familiarity that may be built up over months or years in long-term care situations.

However, one similarity that is common to CNAs in all these settings is an attitude to care that perceives ‘good care’ as encompassing both instrumental and affective elements, and that views care that is simply instrumental as substandard or lacking. While much has been written about professional norms proscribing emotional elements of care, according to my interviewees at Northside Hospital this was not mentioned at all by supervisory staff. There was no sense of the role conflict that has been found in other healthcare setting (Berdes and Eckert 2007; Cancian 2000).

There were three main findings concerning the affective elements of the care CNAs provide. First, they see care that is purely instrumental as substandard, and aim to give a more complete care that includes both instrumental and affective care. Second, although they are not legally responsible for the care they give, they have a sense of responsibility for “their” patients. While on the instrumental side, their limited scope of practice means that they cannot provide medical interventions, they take responsibility for their patients in an expansive way that includes ‘making patients comfortable’ by providing a human touch and caring for the whole person; being concerned with their emotional as well as physical well-being. Finally, while emotional labor is not part of their formal job description, emotion work is used, particularly in difficult situations such

as dealing with difficult or violent patients and when CNAs are comforting dying patients and their families.

Caring For Includes Caring About.

The CNAs I talked about frequently mentioned the need to show compassion and empathy for patients, and that staff who were cold and distant were not giving good care. Luciana emphasized that her work was about more than simply performing the care tasks, but that treating people with kindness and empathy was also important, exemplifying the idea of caring as incorporating both instrumental and affective work:

Yes, a lot of them go, “good morning”, and they’re as cold as ice. They go in there . . . grab their hands to do the blood pressure, and then they’re out, whatever. They don’t tell us that, it has to be you . . . You know that some people go and do their job, but they’re doing what they’re telling them, but guess what? They’re cold, because they don’t care. If you don’t care to do that CNA work, you’re not gonna do it right, cause it’s very demanding, it’s very hard . . . If you teach these CNAs to . . . do your work, be polite, be nice to the patients, you know- they’re here because they’re sick, they’re angry, they’re dying, God knows, right? I say, my God, we’re lucky, we’re walking, we’re okay. These people are coming here because there’s something wrong with them . . . I’m like, look at these poor people. This is how I see it mentally (Luciana, personal interview, February 18, 2013).

Like Luciana, James too resented workers that he felt didn’t care about the patients, and just put in their hours:

I mean most people don’t really give us credit you know, like it is really once you get used to the gig, it seems like it is hard especially when I work with people just who don’t care about the patients. They just want to be there to finish their shift and maybe whether you are trying to work hard and then they don’t, you know (James, personal interview, May 21, 2013).

Charles also used empathy to try and understand what it was like to be dependent on someone else’s care:

I’m in this occupation because I do love taking care of people, I do love connecting. Connecting, I think that’s a big part of the human experience. . . . Patients are here and they’re almost always at their worst. They’re in extreme

pain. Something's happening that's not okay. A lot of independent proud people are having to receive care for things that they would rather do independently. Here I am at four o'clock in the morning asking them to turn over so I can look at their bottom or clean them. Things of that nature. And it's hard, so I hope that if we can introduce the human element of that and get to know them as a person, it makes a difference in their stay (Charles, personal interview, June 18, 2013).

Alex aspired to that ideal, but found that personal issues, like pain from a back injury and a problem with anger management. This meant that she sometimes fell short, something which patients and their families noticed:

Another thing I wasn't so proud of one time, while on that subject, my back – I know it's never an excuse, but that's how painful my back has gotten. I had done everything for this one patient and I was trying to go to another one who was yelling at me and this other lady pulled me aside and said, "My mother needs help." And I had lost my cool, and I went, I just, "Oh my God!" I went in there and I straightened the patient, and it's like, "You're not touching my mother, not with that attitude." And I'm just, like, "I'm straightening her out" . . . But one thing the hospital's really taught me . . . was that . . . you can't do it all, you gotta really maintain the utmost patience and it's the hardest thing to do, but it can be done. And that's an achievement that I've actually built, feel really good about that I've developed in the past years of working here. But if anything that has made me really regrettable at the end of the day it's how I haven't handled things with my attitude (Alex, personal interview, January 15, 2013).

All the people I interviewed for this study expressed similar attitudes to care; that simply doing the reproductive tasks was insufficient to their ideal of good care, and that CNAs and nurses who did not have that attitude were failing in their responsibilities.

Family metaphors for care. One of the most common ways in which CNAs emphasized the importance of affective care was in their frequent use of family metaphors or, more accurately, similes. As in longer-stay health settings, CNAs at Northside Hospital often made comparisons with family care, but not in the sense of seeing their relationships with patients as ones of fictive kinship, but rather in using the simile of family care as the benchmark for the standard of care that they aspire to give. Ruth who, like many of my interviewees, was a Latina, made an overt link to the fact that

many of the patients at Northside Hospital were Hispanic, seeing her work specifically as giving back to her community:

And then, especially working with a lot of Hispanic people . . . I feel like I'm contributing back to my people in that sense. . . . I know it's kinda bad to say, because you're not supposed to, but to a degree I do look at almost every patient as in, "Well, that could be my grandmother lying in that bed, that could be my aunt, that could be my uncle, that could be my brother, that could be my sister." So I look at it like that, saying, "How would I want . . . them to be treated, if it were them?" (Ruth, personal interview, November 30, 2012).

In acknowledging that she was not supposed to view patients as like her grandmother, Ruth, a psychology major, was the only person who expressed some equivocation about the personalizing of patients and its opposition to professional norms of detachment.

Isabella, an immigrant, talked about being unable to care for her mother, but giving the kind of care she wanted for her mother to her patients:

To do this job you have to be very compassionate because . . . sometimes it's very hard. But you have to have compassion and love for people. . . . I work . . . with older patients and because of my mom, that I couldn't take care of her in my country, I like see her in them. I want them to be well taken care of because I think what I wanted for my mom, I want for them too (Isabella, personal interview, July 18, 2013).

In fact, many of my interviewees had personal experience of caring at home for family members, or of family members who had been in hospital, and they drew on that to inform their conception of good patient care. Elena's mother had recently been a patient at Northside Hospital, and the idea of treating her patients as she wanted her mother to be treated was particularly salient to her:

I say I give my care to every patient, just as I do to my own family, cause recently my mother was here, through cancer, so . . . really it hit me more. I mean I've always tried to be like they were my family, so when my mother was here it hit me. . . . I mean, trying to take care of patients here and go see her to another floor and take care of her too. Now I look at them more as a family member, cause you don't know what the other family's feeling. On my side, what I felt like seeing my ma (Elena, personal interview, December 30, 2012).

Melanie's mother had been hospitalized many times, and she once asked her mother about the experience of being cared for:

[S]he said the one thing that she'll never forget is that her CNA spent an hour after work staying with her and gave her a bath, and brushed all the knots out of her hair, and she said that no one had ever done that. And she said that if she could remember her name or her face or even the hospital that she was in, that she would go back and thank her, in any way possible. . . . So with her saying that I know it means a lot more, it's a lot easier when you're able to do it yourself. So I try to keep that in mind, the little things like that. They definitely don't overlook that when they're not feeling well (Melanie, personal interview, May 30, 2013).

Hearing about her mother's experience emphasized the importance of providing elements of personal care that went beyond simply the medical and hygiene tasks, and showed that patients may remember being cared for in a compassionate way far longer than the details of their medical treatments.

"Everybody's somebody special to somebody." Another way in which CNAs revealed their attitude to care was in their disapproval of the expectation that some patients should get special treatment because they are family members of doctors or other staff. There were no explicit questions about this in the interview schedule, yet it was brought up by many of the interviewees. Elena's comment is typical:

I really don't try to say, oh, this person works here so, um, watch that family member a little more, they're VIP. We get that once in a while, I don't like it, you know. To me everyone is a VIP. Everybody's somebody special to somebody (Elena, personal interview, December 30, 2012).

James also pointed out that patients were paying for care one way or another, so all deserved equal treatment:

They should be treated all equal. Because in my experience sometimes you know if they say, "Oh, that is the family of so-and-so and . . . that is the uncle of one of the doctors and they needed to be treated specially." . . . If they are all paying, they worked for those- the insurance and those benefits, Medicare- they worked for it when they were young (James, personal interview, May 21, 2013).

While at Northside Hospital the expectations of VIP treatment were informal, Leah had previously worked at a hospital where there was a more formal system:

I worked at [Another Hospital] for 5 years. . . . There they have something called VIP patients, if they're really rich, people who have donated to the hospital. We have to do excellent, you know, 'superior' care with these people, but . . . I don't like treating anyone better than, you know. Everyone deserves it (Leah, personal interview, February 11, 2013).

The CNAs argued that all patients should get the same, excellent, care, and that CNAs should do what they could to make each patient feel special. But when unpacking the idea of the "same" care, it was clear that what they mean by this is individualized, appropriate care. All patients should get the care that they need, both for their medical condition and for their social and emotional needs. As Anne, who at 19 was the youngest CNA I interviewed, explained:

Everybody's equal for me. Everybody's here for care. There's no like special star or special place. . . . If there is any special needs, yes, I will address the special needs, but . . . everybody's patients for me. Everybody's here for care. Everybody has the same rights. That's what I believe in. If somebody needs extra care, yes, I will do that. Yeah, but other than that I do best for everybody (Anne, personal interview, June 18, 2013).

Luciana, who had decades of experience, felt that listening to patients and meeting their emotional needs, as well as the physical ones, was an important part of making patients feel better:

For myself, I take the time with them. I make sure that I'm doing what I'm supposed to do. If something is going wrong with their life, or whatever, even though I don't know, and they're talking to me, I try to make them feel better. Not to tell them what to do, giving advice about, oh, I'm like, "No, you know what? Just see it this way," or, "Don't worry," or, "You know, everything will be okay in a little while. Let's -" you know what I mean? I just try for them to feel better, or, "Don't worry," or, "I don't know." I just feel person to person and I have to see what they need, what they need from me (Luciana, personal interview, February 18, 2013).

Charles also emphasized the importance of making a human connection to individual

patients while doing what he could to make them comfortable:

The individual needs of the patients are so different, it's hard to categorize that . . . I hope and I aim for a high standard of care and a consistent standard of care. But things happen with certain patients, you know. Maybe they're taking a medicine that's not agreeing with them and they're in extreme pain and you stood there for two minutes and held their hand, or you ask them, or you calm them down, or you look them in the eyes and said, "Let do breathing exercises, follow me. Look at my nose, we're going to deep, deep breaths in and yoga breaths all the way down to our belly," and spending that time, you can feel that human connection, it's really special. When you miss that mark, you know too. . . . You feel it right away when something was missed, and those stick out as well (Charles, personal interview, June 18, 2013).

It is significant that all the male CNAs I interviewed had similar attitudes to care as the women, expressing the importance of empathy and warmth in their care. However, men have particular challenges in providing personal care because caregiving is so strongly associated with women. The men I interviewed had a variety of strategies to deal with these challenges.

Male CNAs – Negotiating Gender on the Hospital Floor

Around one in eight of the CNAs at Northside are men, (data from Northside Hospital), which is similar to the national figures of 12% for CNAs in all settings (U.S. Census Bureau 2011). I was able to interview four of them, one fifth of my sample. Obviously the small sample does not have any statistical significance, but the interviews raised some interesting points about men in predominantly female occupations.

Charles, the only white male CNA I interviewed, had completed several years of university and planned to move into a technical healthcare occupation. He argued that male CNAs were more likely to make a positive choice in choosing to be a CNA, because it was unexpected for them to go into the job:

I'm the only man on my shift, but there are men on first shift, both nurses and

aides, there's none on second shift both nurses and aides and I'm the only man, I'm the only CNA. . . . I'm not boasting, but I have a very calm caring personality, I come from a big family, I've always been that sort of more nurturing type, so I know that I fit within the role and I know I can fulfill it. The men that are in this profession are extremely caring, I had someone say to me once that she would rather be taken care of by a man because she knows that the man who are here, who are in any medical realm, both nurses and CNAs, are there because generally they care and they have a very nurturing side. . . . They have to really feel a connection with it (Charles, personal interview, June 18, 2013).

However, Charles felt that nursing staff had particular gendered expectations for male CNAs, calling on them for tasks requiring strength, for example. He states:

I joke that I was only hired for my body. I call it, "Chuck, heavy lift patient, come on over here" (Charles, personal interview, June 18, 2013).

While men are still in a great minority in nursing occupations, the numbers are increasing slowly, and patients are more accustomed to dealing with male caregivers. Nonetheless, some women are uncomfortable receiving personal care from a man. Since most of the nursing team are female, male CNAs can usually call on a female CNA in these circumstances. However if they are the only CNA on duty (for example, at night, or if there is a low census), they often have to ask a female RN, which is more complicated. James mentioned that if the patient did not want a male caregiver, he switched patients with the other CNA:

Since I am a male, now some female patient would get uncomfortable with me so they rather have a female, so that is we switch patients, I don't know. She will pick up one of my and I will pick up one of her patients (James, personal interview, May 21, 2013).

If he was the only CNA on duty, he had the option to approach the charge nurse to find an RN to take the patient, but he felt that sometimes this was seen as slacking off:

I would go and approach my charge nurse and say, "You know, if . . . there is anything you just can do, I mean this patient doesn't want a male CNA." . . . So it depends on the charge nurse. . . . Sometimes there is some deeper layer that you just don't want to do the work (James, personal interview, May 21, 2013).

George, a younger CNA, said that some female patients were reticent about receiving personal care from him, because he reminded them of their sons or grandsons. He negotiated this gender and age issue by emphasizing his experience and familiarity with care:

[T]o their eyes I look like their grandson or son. They were like, “Yeah. It’s kind of weird” and, I mean, I try to reassure them, like, “The floor is busy, I’ll try to get the nurse in here” and I’ll attempt to get the nurse in to the room but usually they will say, like, “Oh I’m too busy” so I’ll come through and tell them, “I’m sorry. Everybody on the floor is busy” but I would tell them my years of experience and how long I’ve been doing it and they would feel comfortable (George, personal interview, June 4, 2013).

For some patients there are specific cultural or religious prohibitions against receiving intimate care from someone unrelated of the opposite gender, for example, with Muslim patients (Padela and del Pozo 2011). Understanding this and working around it is part of the cultural competence that CNAs learn from their work. While both male and female CNAs mentioned cultural sensitivity towards Muslim and other women in matters of clothing and unclothing, there was no mention of male Muslims having any problem with being cared for by female CNAs, even though Muslim ethical guidelines concerning cross-gender care also apply here (Padela and del Pozo 2011). Presumably, this is because women are more accepted as caregivers, and because male CNAs and RNs are often unavailable. The men I interviewed had different strategies for dealing with situations where women were uncomfortable with being cared for by a man, but all of them cultivated an awareness based on observation of patients so they could anticipate these issues. Teddy is an older, African, CNA:

Walking to a patient’s cubicle and the patient might be a Muslim, a lady Muslim where they have all their head covered and those things. And I walk in there and I know definitely that they don’t accept any man touching them besides their

husbands and I said, “Hey, I understand you are a Muslim. I’m going to call a lady to come and take care of you.” And the other thing is, “If you don’t mind, I can do that but I’ll get a lady to come in,” and then they say, “Well, thank you.” Those things I quickly observe and I do that (Teddy, personal interview, May 18, 2013).

Charles’ way of dealing with it was not to make an issue of his gender unless a patient brought it up:

It’s the tabled issue or it’s the back burner issue. . . . I’ll approach it and if it will become something later, I won’t say, “I’m your male CNA.” I won’t say, “Sorry you have to have a man tonight” (Charles, personal interview, June 18, 2013).

However, he was careful to try and meet the patients’ need for a female caregiver, while stressing that the medical needs took priority:

I try and watch the body language and I look up for cultural clues as well, and I will offer in those circumstances, and this is reserve request, I won’t flat out say this, most of the time I’ll just do what needs to be done. But if I notice hesitation, again, I’ll look for cultural clues. I say, “Would you prefer a woman?” or, “Would you let me send in one of the female nurses?” And I’ll go accordingly with the patient’s wishes. I don’t want to offend. That being said, emergency situations and dire straits we’ll do what needs to be done regardless of the individual patients, but we have addressed the medical need and for everyone there, that’s what needs to happen (Charles, personal interview, June 18, 2013).

Charles also mentioned that patients who were initially reticent to be cared for by him changed their mind when they got to know him and felt more comfortable with him:

Often if I’m asked to not be present, for instance it’s usually a cultural or religious reasoning and I completely respect and understand that. Often though, over time, especially if the patient stays one or two nights that they get to know me or meet me, they become more comfortable, and I’ve had many patients who the first instance will say, “Can a woman come in, could you send a female and send the nurse in?” but maybe one or two [nights] after they’ve gotten to know me, they said, “It’s okay, you can help me with that.” I had a patient two nights ago who wouldn’t let the male nurses or aides on first or second shift help her toilet, but she had no problem with me toileting her, I’d taken care of her three nights. Not even hesitation (Charles, personal interview, June 18, 2013).

Even when female patients are reticent about being cared for by a man, developing a relationship of trust may overcome that reticence, and as male caregivers become more

common, patients may be more accepting of them. As Charles pointed out:

For some patients, because they're in the hospital, they're more and more used to seeing men nowadays. . . . People say this all the time . . . "Oh, years ago you'd never see a man and now I see men all the time." So they're a little bit more expecting of it (Charles, personal interview, June 18, 2013).

Sense of Responsibility for Patients

One of the things that stands out about the attitude to care held by the CNAs I interviewed is their sense of responsibility for patients. While they are not legally responsible for the care provided, they do feel responsibility for the well-being of patients. Graciela had very recently passed her RN certification, and would soon have legal responsibility for nursing care, but her attitude was also held by the other CNAs:

I don't know if it's something selfish or not but, and I call them my patients when I have them, like owning the responsibility of taking care of them whether you're the CNA or the nurse. . . . I think it's important, whether it be for your shift or whatever (Graciela, personal interview, July 18, 2013).

Because CNAs are at the frontline of personal care, they are often the first to see that something is amiss with patients, and the first to take action, as Luciana describes:

So, I tell you, it's a tough work. They don't realize . . . the responsibility that we have, they have no idea. If we was just there to clean and everything, guess what? I'm the one that saw when the patient was going to choke to death, where he was gonna fall, or he was acting crazy, and this and this and that. If it wasn't for me, God knows how many lawsuits they would've had, or how many of this or this and that. They don't realize what a CNA does. They have no idea. Up to now, they don't know (Luciana, personal interview, February 18, 2013).

CNAs often feel powerless that they are so restricted by their scope of practice in what they can do for patients, and in many cases feel that they are just the conduit of information from patient to RN, like Alex:

I know I can't solve every problem, deep down I sometimes wish that I could, or had more authority, or education to do so, but I currently, that's not my job, it's just relaying the information. So I feel kinda stuck sometimes if I can't do something for them (Alex, personal interview, January 15, 2013).

Luciana emphasizes that CNAs can't always rely on the paperwork and instructions, and need to be proactive in checking that circumstances have not changed, something which is common in fast-moving hospital settings:

I have to make sure that everybody's set up to have breakfast, that they can reach the food, especially the elderly people. But the people that are up and around, I just make sure that they have a tray, cause sometimes they don't bring them one. Sometimes something happens, because sometimes they have tests and they were NPO that night, but the test was done yesterday and nobody . . . changed nothing on the computer. We've come in, so we're the next shift . . . and I'm like, "You didn't get a tray?" She goes, "No", so then I have to go and ask the nurse, "Why isn't she eating? Why didn't she get a tray? You know, is she NPO? What's going on?" Then, they go back and they're checking, okay? But if I don't go check, the nurses will say no (Luciana, personal interview, February 18, 2013).

Teddy also found it difficult when patients were uncomfortable but he couldn't respond to their needs, because it was beyond his scope of work. All he could do was convey his concerns to the RNs who did not always act immediately:

There are certain things I can't go beyond and I feel the patient really need it and then I keep telling the nurse, this patient needs this— this needs to be done and they are not doing it and I can't do it. Like a patient talking about being uncomfortable, he's in pain and I keep going to the nurse and say, "This patient is in pain." They're saying, "Oh, I just gave him some medication" and I say, "Why don't you go in there and see what you can do next? Maybe what you give wasn't enough." . . . "Oh, as soon as I'm done with this, I'll do that." And I thought, those people are not getting what they need to get and they are not responding well to them, and I feel bad because I see their emotion, I see how they are reacting and the nurse doesn't seem to. And when you go and beyond talking about that too much, it looks very unprofessional because they can hear us and they can see our reaction (Teddy, personal interview, May 18, 2013).

Teddy was clearly frustrated that his scope of practice limited the medical care he could give, something that other CNAs also expressed. However, this did not limit their feelings of responsibility for the care they provide for "their" patients.

Caring for the whole person. It seems that in the absence of legal responsibility for the instrumental tasks they perform, and the limits to their scope of work regarding

medical tasks, CNAs take on a greater sense of responsibility for the overall well-being of patients, including their emotional and social well-being. This fits into Foucault's concept of pastoral power, where the "shepherd" knows each of his flock individually, and provides for their individual needs (Foucault 1988; Lee-Treweek 1996).

Many CNAs emphasize the need to spend sufficient time with patients to meet their individual needs, including time to talk and not to feel that they are part of a "production line" of care. But there is also the time crunch of having to deal with the hospital's priorities and tasks, and they are sometimes pressured by RNs to finish up quickly and go to another room. This is frustrating, not being able to spend the time they think is necessary, or not being able to complete the tasks they had prioritized. James' comment reflects comments from many of the CNAs:

There is so much to do. And you know that . . . now it is you have to do the second set of vitals, you have to do your AccuChek, blood sugar . . . before this. Certain times, because once the kitchen people would come up to the floor and deliver the trays. And you have to rush and rush and then . . . and call lights are calling and then you can't get there on time and then you go in the room just when they get upset (James, personal interview, May 21, 2013).

Sandy, an experienced CNA approaching retirement, stubbornly resists the nurses' attempts to rush her:

I'm going to do the same thing that I'm doing for this patient, give me time to finish this patient. . . . Or, if you're gonna rush me, which they have, but I said, "Okay, is it an emergency?" "No." I said, "Okay, I'll be there when I finished with this – number 17." They don't like it that way (Sandy, personal interview, February 14, 2013).

Elena's words on reassuring patients who may be scared and upset reflects those of many other CNAs who have learned that simply listening to patients may be more important than sticking to the schedule, however tight:

When I go in my rooms and I try to talk to them, personally, or they'll talk to me

and I just listen to them, cause they can be, themselves, they're scared and they need to vent what they're feeling. So usually . . . I don't mind if I'm falling behind a little bit . . . because to me it's more important what the patient's going through. . . . I try to let the other nurse know, "I'm in with so-and-so, so you need me, come and get me" (Elena, personal interview, December 3, 2012).

While many CNAs told me that they try to provide the best care for everyone, some went to extraordinary lengths to meet patient's individual non-medical needs.

Luciana talked about her treatment of a young, homeless man:

And it was this particular young man that came from the streets. And he was so dirty and everything, my God, I think he spent the whole day in the shower, the poor guy. . . . The room smelled so bad. I felt so bad. And it wasn't because of him, it was his clothes. So I told him, "You know, I'm coming back tomorrow. Let me take your clothes. Let me wash it for you. I'm not gonna steal your clothes, you know." . . . So I did, I took it home, . . . washed it, I cleaned my washer . . . because I couldn't stand the smell. . . . Because, what happened before, there was another homeless guy, he had dirty clothes, they threw it away. They threw all his clothes away. And you know what? They gave him clothes that didn't even fit him. They sent him home with the pants all the way up here and stuff, you know? . . . I treat them like human beings, like what they are, cause a lot of people are very bad with them, with the homeless people. I see how they talk to them. They treat them like . . . animals from the street or something. They don't have no respect. They respect everybody else (Luciana, personal interview, February 18, 2013).

Melanie bonded with a patient who spoke little English over a shared love of music, and did her best to make this patient feel comfortable in the institutional hospital setting:

I've had an instance where a patient didn't watch TV at all and spoke broken English, but I asked her if she liked music. We don't have radios here so it makes it hard, and if it were me, I love music- I don't really mind the TV, but I'll be fine with music. And she said that she liked an artist that I never heard of, from way back when, from her country. So it took me forever to find it, but I finally went home, downloaded the album and came back the next day, and I put it on play and I left it in her room, so when the CNAs or the nurses were feeding her, she felt comfortable. She felt just fine for the rest of the day. . . . I kept it on there because I kind of got used to it, and it reminds me of her all the time. . . . [Y]ou get to know something about everyone (Melanie, personal interview, May 30, 2013).

Isabella works in the extended care facility, which provides rehab mainly for elderly patients, and talked about going out of her way to make individual patients feel special:

I have this patient in 141 and she likes tea. She loves tea. I love tea too. And sometimes she wants tea but the breakfast comes early and the lunch, I'll say 11:30 but after that sometimes she wants a cup of tea so, I say, "Oh! Not a problem. I will go downstairs and I will get you hot water or I will heat some water for you and I will bring you the hot water" and she finds that so nice. . . . So if they need something or I have no problem going to get it, washing their hair or doing something to make them feel nice (Isabella, personal interview, July 18, 2013).

Teddy's work in the wound care unit means that he often sees the same patients regularly over a long period, and the care during that time is very hands-on, so his interactions have a different character to many of the staff who work in inpatient units:

Within two to three visits [they] will become like family. So we are always interacting. . . . So I have that kind of connection with them. Sometimes if they have a bad day, we recognize that one and we give them a card. And some we ask them how was their weekend or how did the week go or if anything happen in the family? Sometimes they are open to share and I talk to them about it. My last patient I saw was a gentleman who lives in the nursing-like an assisted living home and anytime I see him, I realize his lack of clothing. He doesn't walk properly—you can feel he hasn't got it. And so I went into my closet and I brought in a whole bunch of clothing and shoes and then when he was living there he was like a millionaire. He was telling everybody how closer he's felt and how important we are in his life and those are some of the things that I do (Teddy, personal interview, May 18, 2013).

Luciana works in a unit that specializes in pediatric patients, and has a large family of children and grandchildren herself:

With the children we get . . . a lot of poor people come or whatever [sighs]. My daughter has 5 children, she has four girls and one boy, guess what? All their clothes . . . we're buying and my daughter's the type of person that . . . recycles everything. . . . I always get the bags, and when the patient comes and I know they need the clothes, guess where the clothes is going? To them. . . . I might not see them again any more, but, you know? I already did that, you know. I don't keep in touch, these 14 years I have never kept in touch with nobody (Luciana, personal interview, February 18, 2013).

But even the most straightforward examples of the "human touch" that CNAs bring to their interactions are appreciated by patients, probably because so many of their interactions with hospital personnel are for purely medical procedures. As Melanie, a

young CNA on a medical surgical unit put it:

I think when they're going out of their way to thank us, most of the time it's because we didn't act on them as just some other patient. They have a name, they are here for something specific that we know about, they have things that make them happy, things that make them sad, they have goals, they have things that they want to get to do. Patients that can't walk, where we've gotten them with some assists, they went to rehab, now they're walking I think it has to do more with how much time certain people took to stay with them. Even if it's just talking it makes so much, them better. Or they might be scared to just sit up on the side of the bed, and that nurse or CNA or even the therapist just sat next to them just to make them feel more comfortable for a few extra minutes to see how far they can do it themselves (Melanie, personal interview, May 30, 2013).

Marta spoke about visiting with a patient who she was no longer assigned to, to chat to him when she had time:

We have a patient now that even though he's not my patient I still go in there. I say hi to him. He's one that you can joke around with. So I'll go in there and I'll say, "Didn't I kick you out yesterday?" And, "Why are you still here." He just likes to be talked to. It makes him feel good because he's in a lot of pain. So I feel . . . just doing stuff like that it goes above my role as a CNA when he's not my patient. . . . His wife comes in and brings up food all the time . . . and she's like, "I don't want him to leave," because she's scared to take him somewhere else because we know him. We know his weaknesses, his strengths. We know how to push him to make him know that he's capable of doing what he can do (Marta, personal interview, May 23, 2013).

CNAs regularly mentioned the need for compassion and empathy, and engage their emotions at work. However, the extent to which they perform emotional labor is a complex question, since simply having emotions at work does not constitute emotional labor. While Lopez (2006) describes a continuum from emotional labor to organized emotional care, the emotion work of the CNAs that I interviewed does not really fall into the category of organized emotional care, either.

Emotion Work and Emotion Management

Much has been written about emotional labor as a requirement of many service jobs, including care work (Hochschild 1983; Leidner 1999; Lopez 2006; Rakovski and

Price-Glynn 2010; Theodosius 2006; Wharton 1993). However, it is not clear that the emotion work and emotion management that CNAs perform at work qualifies as emotional labor, since workers are not required to perform emotion management by employers, except in contexts where emotional displays would be seen as unprofessional. On the other hand, it may be that emotion work is assumed to be part of the job, but is not clarified or codified. Unlike residential care homes and nursing homes, where a caring attitude to patients is commodified, with the metaphor of “the family” as the commodifier, (Berdes and Eckert 2007) the main purpose of acute hospitals is medical, and efficiency and efficacy are the main institutional priorities.

While interviewees talked regularly about the need for compassion and empathy in their work, there were three kinds of situations in which *managing* emotions (rather than just *feeling* them) was discussed. These were dealing with difficult patients, dealing with violence at the hand of patients, and caring for dying patients.

Dealing with difficult and demanding patients. CNAs may talk about certain patients with affection but not all patients are easy to care for and some may be demanding, may fail to co-operate with their care, or may even be insulting. When faced with patients whose behavior was difficult, mean or unpleasant, CNAs tend to respond with one of two opposing strategies: “being professional” or “killing them with kindness.” “Being professional” meant just doing the instrumental work and withholding the affective work. CNAs following this strategy provided the minimum level of care required for the job and spent as little time as possible with the patient, while being polite. This can be seen as an expression of power by the CNAs; the power to withhold affective care. In this situation, CNAs had to manage their negative emotions and keep

their cool. “Killing them with kindness” meant trying to change the patient’s attitude or behavior by being extra nice and friendly. CNAs following this strategy managed their emotions by empathizing with patients and rationalizing their difficult behavior as arising out of pain, confusion or dementia, or fear. This is reminiscent of the way that flight attendants deal with passengers who are difficult (Hochschild 1983), something that has also been observed in nursing homes (Åkerström 2000; Berdes and Eckert 2007; Lee-Treweek 1996).

While my sample size was too small to make definitive statements about this, there did seem to be a gender difference, with male CNAs tending to take the route of sticking to the instrumental tasks, and female CNAs amping up the affective side of their care, something which is in line with previous studies of emotion work and emotional labor (Hochschild 1983). Teddy, an older, black CNA explained how he dealt with patients who had a bad attitude about his race by reporting it to senior staff and keeping things strictly professional- doing his job, but no more, and with no banter:

I have had patients who are very, very, very racist, that when I walk into the room they feel uncomfortable and when I try to talk to them and they are giving me cheeky answers. Sometimes I just keep quiet and then I just say, “My name is Teddy, I’m the CNA and this is what I’m going to do for you. I’ve come to take your vitals and then clean your wound and I’ll do the necessary and the doctor will come and see you.” So it’s quickly and out. And some have passed comments. Like “Oh, that black boy this and that,” and then the doctor will say, “Well, his name is Teddy.” And then they say, “Oh! Well, he did a good job.” Although they don’t like me, but I go to the professional level and then out. And when I see them, “Hello, how are you doing?” And I say no more. And, believe it or not, their second visit, they come around. I had one that is always passing and, you know, this “Africans and this and that,” I don’t say anything. I finish everything and then I will tell my supervisor, “This person is making such comments” and then my supervisor walk into the room and, “You don’t do those things over here. If you are not comfortable about the staff who are working here then I think you have to change your doctor.” I don’t say anything to them. I don’t reply them back and no matter what you say, I just keep quiet and then I walk out

of the room (Teddy, personal interview, May18, 2013).

Charles discussed how he dealt with situations when he found himself losing his cool:

Defuse, try and communicate what's going on without raising my voice or without being sharp. Holding my tongue is a big part of that. There's plenty of things that I personally feel should just be water under the bridge and let it go rather than make it become some big thing, so those are my own personal strategies, whether they're best or not, I'm not sure. Walking away, taking a break. If it's as simple as going into the restroom just to shut the door and stand in front of the mirror for two minutes, questioning my life choices, that's how I need to do in that moment, that is it (Charles, personal interview, June 18, 2013).

Sofia, from the maternity unit, takes the opposite approach:

I have a tendency to just kill them with kindness. Just be kind. Try to accommodate, . . . keep a realistic goal of the care and that's it, that's all I can do. Yeah, but just be kind, because they're already there in a hospital setting. It might not be something they're used to or they're just, they want to go home or - but usually our patients, like I said, they're very pleasant because they're only there a short amount of time (Sofia, personal interview, June 13, 2013).

Anne, a young, Asian CNA, had learned to cope with patients who were difficult or uncooperative with a sweet and happy demeanor and by joking a little with the patients about her name:

There are some patients who are really mean. People who don't want to do anything. But I try my best to convince them. . . . I tell them, "This is important, we really need it. This is a part of your care so we can provide you with a better care." And they will get it. They will understand that. So if we tell them in good way like in a kind and soft with a soft voice and a sweet smile they will understand it. . . . I never go beyond the professional but . . . most of the patients they are not happy especially if they come up to here and they know something is going on and that's why I'm here. So when they come up here we don't want them to be sad. So especially with my name, that's the only thing I can say, "Oh, I'm from Green Gables." That makes them happy. That's a big thing. They're all like, "Oh, that's a good joke. You wouldn't think you're from Green Gables." So they will smile (Anne, personal interview, June 18, 2013).

Isabella, who works with older patients in the extended care facility, had a similar strategy:

I have to deal with different type of personalities. . . . If the patient is difficult, you

try to be nicer. That's what I do, I try to be very sweet, very nice and they see that I'm compassionate and then they change, you see. They will turn around. Because if you go and you're mean, well, "I don't have time to take care of you. Why do you call me, what do you want?" . . . instead of saying, "Can I help you? Do you need something?" instead of that aggressiveness, that's why patients turn like that. I give respect because that's what people want, right? If I'm respectful to you, you're going to have respect me but if I'm mean to you, how are you going to act? (Isabella, personal interview, July 18, 2013).

When patients are uncooperative, "killing with kindness" can also incorporate elements of Foucault's (1988) concept of pastoral power in persuading patients to do what is required (Lee-Treweek 1996). An example of this is when CNAs depend on patients' willingness to please by pushing them incrementally to do more and more.

Laura, who works in the IMCU, gave an example:

There are a couple of times that they do refuse and it's like okay, you can't do anything about it but there's other times . . . that I go in there, "Okay, can you get up, can you please like sit up? You got to move your arms at least." Or when I'm taking their blood pressure. . . . When it comes to cases like that . . . since they will just lean there on the bed, I just tell them "Can you lift your arm up? Can you put it down? How about the other one? Okay, down." And then the leg. And then just . . . throwing little stuff at them like that. . . . That's one example of how I know I did more than I had to by pushing them. And I'll be like, okay, once they're in the geriatric chair, "Do you want to go to the bathroom since I'm here already? I can help you to the bathroom." They'll go to the bathroom. Once they're in the bathroom, "Do you just, might as well want to comb your hair and just wash your face a little?" I got a feeling like I will go in there with the . . . towels and everything ready. If they want to do it or they don't want to do it, the stuff is there already . . . So the ones that end up doing it, I keep pushing them: "Okay, you're in the bathroom already, you can brush your teeth, you can wash your face, rinse your hair, brush your hair. Okay, now you're done. Okay, do you just want to change your gown?" They'll be like, "Okay, might as well. I mean, I already did everything else." So then they will change the gown. "Okay, do you want to go back to bed or you want to stay in the geriatric chair?" And they'll be like "Oh, what do you think? I'm up already." I was like, "You can stay on the chair and you will be ready for breakfast." So they'll sit there, they'll just like be watching TV but my thing is like, okay, I'm coming out the room, everything is done in there already. And convince them to do it little by little but they end up doing it (Laura, personal interview, June 11, 2013).

Leah had a demanding patient who was complaining about her care, and recognized

immediately that she was a retired nurse. She used that fact to empathize with her patient and to make an extra effort to make her comfortable:

We had a lady in four, she was a nurse, I knew that right away [laughs]. You always know a nurse! She didn't tell me, I just knew. Like, in the morning she was upset because she didn't get her coffee. Then she was saying, "Oh, the food-service here is just totally rundown" and, you know, I had the feeling that she had the feel of the hospital, so I was like, arghhh! And then later I came in, she's like, "I feel terrible, no one's changed my bed since I've been here, I need to clean up." So I changed her bed, I helped her get cleaned up, new gown, washed her a little bit. Then she said something, "I been taking care of people all my life." And then I said, "Are you? I know you're a nurse," and she said, "Yes, I've been a nurse for, like, 30 years." That was nice, you know, we can all relate to her (Leah, personal interview, February 11, 2013).

While patients may be rude or uncooperative, they may also be physically violent to their caregivers. As discussed earlier, CNAs often view violence through a different lens. These situations can be particularly stressful, but both male and female CNAs use empathy and emotion management to minimize the actions of the patients, so they can carry on caring for them.

Assaults: "You can't get mad at sick patients." Like CNAs in nursing homes, most CNAs had stories about violence experienced at the hand of patients. However, in hospitals there are protocols and greater resources for dealing with violent situations, including a bedside alarm to alert other staff, and escalation to a 'code green' alert that will summon hospital security staff. Some units also use a variety of restraints for violent patients, often to stop them hurting themselves as well as staff. Melanie, a young CNA from a Medical Surgical unit, explained the escalation procedures:

If they say, one little thing, we'll ignore it. If it's a CNA, we'll let the nurse know if . . . they did something inappropriate, just heads up, and I'll do the same if the therapist or the dietary [aide is around]. . . . We'll just let them know, you know, "Just keep your distance, the patient was inappropriate earlier with another employee. Just watch yourself, or if you go in, go in with someone else or give

me a call if you need any help. Don't close the door," stuff like that. If it escalates, we will call the code green. If they're being combative, we're going to call a code green regardless, especially if they're alert. . . . It will go off in the whole hospital just like the code blue or something, and they'll know exactly where and they'll have two or three security guards come up, kind of just assess the situation. See how it is, if they need to keep a security guard up there or not. From there, it's they get restrained. I don't know how it works on the other floors, but our manager is strict on no restraints, we don't use restraints at all. The most we'll use is the mittens. I think I've seen restraint one time in the last year at least, and that was just from the emergency room up to the floor. Once they got up to the floor, we took them off, and the patient was fine, actually, so it was fortunate for us (Melanie, personal interview, May 30, 2013).

Several CNAs mentioned that, particularly with confused patients, it was possible to intervene if the patient was getting violent or aggressive by distracting them, as James, who works in critical care, explained:

[If] I was having somebody getting violent . . . I would carry a conversation with them that would divert their attention, . . . just talk about something. You see a picture on the wall, "Oh, look at that. Is that your mother or it is you?" And they would- sometimes it works. Sometimes it doesn't and it depends (James, personal interview, May 21, 2013).

Like other CNAs, Marta dealt with her emotions by venting to other staff or to her family when a patient hit her:

I just stepped to the side. I got out of her [way]. I'm at work, so can't react like if a person just came up to you in the streets and smacked you. You still have to respect them as a person even if they're not fully there. So then I vent at home or, you know, I'll vent to the nurse, "You know what? She just smacked me." So you just kind of vent to each other about it. . . . I know it's part of work (Marta, personal interview, May 23, 2013).

Hospital CNAs minimize patient violence in the same way as CNAs in nursing homes; they use various "frames" (Goffman [1974] 1986) to deny that it meets the definition of violence (Åkerström 2000; Berdes and Eckert 2007). The most common minimization strategies were that the aggressor was frail or old, so their assaults did not meet the threshold of violence, or that the aggressor was confused and did not mean to hurt.

Another reason given was that when patients did not speak English, they were unable to understand when CNAs explained what they would be doing, and became angry.

However, there are a wider range of patients in acute care hospitals than in residential care, including people with mental health, addiction, or behavioral, problems in addition to the acute physical conditions that brought them to hospital. These issues can add another level of difficulty to patient care. Melanie used empathy and emotion work when she had to deal with a difficult situation with a patient who had learning disabilities and severe behavioral issues, even though she was a new CNA with little experience:

We've had a mentally challenged patient, who was maybe not even 20. . . . And I had just started here, so it was all new to me, and my manager thought that I could handle it and stuck me in the room, so, I think you're a lot stronger than a couple of the other girls here who had kind of been battling, trying to keep her calm. And I managed, but . . . I got swung at a few times. It got to the point where she was pretty much trying to bang her head at the flip cart, like the head board . . . of the bed. . . . And the mom was there at all times, but she wasn't able to really help with anything. And we ended up taking the bed out and I went into an empty room and grabbed another mattress and we literally padded the whole floor so she could go at it, because there was nothing else that was going to help. She was going to hurt herself, but she didn't know any better. So by the end of my shift it took two of us to stay and we got to learn that she had a nickname, and . . . her recognizing that someone else recognized her nickname made her feel like, I guess, a little more comfortable . . . and it got a little bit easier, but overall it was ongoing. The medicine, nothing was going to stop her and she had been like that at home, she had been like that in other places. She was there for a medical reason- . . . maybe like a UTI or something simple- but dealing with the behavior alone, and even the family couldn't control it. . . . I can't imagine how you do it at home when sometimes we need help and we're trained for things like this. . . . I'm almost positive the mom was a little, like, upset because . . . they did have to give her medicine, so we kind of had to hold her down at one point. And when you have a child who has a mental illness, or if she's challenged, she's here at the hospital, she's young, she doesn't understand, so there's no way of getting through to that person. So she was sad and it was more of a two-patient thing where we kind of had to make her feel better as well, so that was something that I won't forget (Melanie, personal interview, May 30, 2013).

In this case, bringing a personal touch to the situation by learning the patient's nickname helped to calm a difficult situation.

Another sign of minimization is that CNAs often laughed (awkwardly) in telling their stories, a way of indicating that they were competent and could cope with the behavior. Elena, an experienced CNA who works in an orthopedic surgical unit, describes a frightening incident with a patient:

I mean, there was one day that was just, was just horrible. I think she only spoke, um, Romanian. . . . And she would just keep coming out of the bed, off and on the bed, and I just went over there, cause she closed the door, and she had hip fracture, I did not want her to fall. So I went in, opened the door, she had a knife and a fork in her hand. Once I opened the door she tried to stab me with the fork, and I was like, "Oh my God." I jumped back, and as I was jumping back she came with her other hand with a knife, almost hit me in my face, and I kinda like blocked it – I didn't wanna push her, but I kinda shoved her back into her bed, trying to defend myself. . . . I screamed out "Help!" The nurses came . . . and I was just like, "Oh my God – I could've lost my life." [Laughs]. I think it was more confusion of what was happening for herself. We have one CNA who spoke her language, but she wasn't working that day. And then the family only could come, like, every other day. So I guess for that day she did not know what's going on, and was frustrated, and I think she thought maybe I'm attacking her, because I kept, like, "Okay, you know, you have to turn now." . . . I guess she just got frustrated with me, not knowing what I'm telling her. And she wanted to get back at me [laughs] (Elena, personal interview, December 3, 2012).

Alex, also in an orthopedic surgical unit, spoke almost sardonically about an assault by a large male patient, brushing it off:

I've gotten punched, by a two – almost 300-pound Russian man, right in the ribs. That was fun. Actually, his wife was there. . . . She was a tall, big boned lady, and she was right there helping us. He was in pain and didn't want to be turned. Boom! I'm like, "Okay" (Alex, personal interview, January 15, 2013).

Many CNAs mentioned that being assaulted or verbally abused is upsetting, but they minimize it by absolving patients from responsibility for the assault. Charles discussed how he deals with those feelings, including the feeling that he had let down the patient:

First is to remain calm, like any medical situation or emergency. . . . It's helpful to

remind myself that this is due to psychosis, this is due to medication interactions. This is due to extenuating circumstances over which the patient has no control. Accepting that really helps me know that it's okay that I'm getting hit right now. Just, it is, it's fine. With plenty of brothers, I'm used to a little abuse. It's upsetting when both on a personal level and a professional standpoint dealing with the psychological challenges of, say, patients with dementia or Alzheimer's or again medication interactions, the sheer confusion, the constant repeating of one's self, or especially the, I'm at a loss for words to explain this well, being told by a patient directly or indirectly that you've let them down (Charles, personal interview, June 18, 2013).

Another way of minimizing patient assaults was to emphasize that they were too weak to actually inflict damage, which was particularly used about older patients who may also have confusion. Graciela also mentions the indignity of being washed as a reason for getting angry:

The patients that are more confused and they're kind of violent, I've had some patient hit me before. But he was an elderly gentleman that probably wasn't completely oriented and then, like I said, he was elderly, so in nursing home, so he wasn't strong. So he hit me on my chest with his fist, like, because he was trying to get me away from him while I was cleaning him and what's more shocking? Like I said he wasn't that strong. Thank God, he didn't have good aim so he didn't get me in my head or in my nose and maybe I would have, like, cried. . . . But you know what? He's a sick patient. . . . You can't get mad at sick patients (Graciela, personal interview, July 18, 2013).

Melanie felt that one of her patients treated hitting staff as a game. Because she rationalized it as part of his confusion, and because he was too weak to cause any damage, she found it amusing although she tried not to show this to the patient:

We do have a patient who, I'm used to him, he's older and he gets very confused. I don't think he fights out of anger, he actually laughs when he hits you. It's like a game with him and I don't feed into it. . . . I never see him smile so I have to walk out the room and I laugh because that's so cute. It's some kind of - this feeling of accomplishment once he hits you. He doesn't really hurt you, . . . he's literally playing. He's like a giant baby and he's completely [helpless]. He can't feed himself, so when we're feeding he'll just be laying there and he'll kind of look over at you a few times and if you take your eyes off him for a second, his hand goes up. . . . So it all depends on the patient and like where their mind is (Melanie, personal interview, May 30, 2013).

While studies of nursing homes often suggest that care staff frequently infantilize their patients, this was uncommon among my respondents, although it did sometimes emerge when they were talking about older patients with dementia, as in Melanie's description above.

Although it was much less common than in residential care, some CNAs did make a distinction between patients that they thought were angry or violent because of their medical situation, and those they felt just had a bad disposition that they brought with them into the hospital, another form of boundary work (Thorne 1993; Lee-Treweek 1996). However, since patients are only in the hospital for a short time, these categories did not become institutionalized as they do in longer-term care settings (Lee-Treweek 1996). Luciana explained that she empathized with most of her difficult patients, but thought some just had a nasty disposition

The patients who are mad, difficult or whatever, first I have to find out, what's wrong with you? Are you hurting? I know it's medical, or you're going through, you know, denial, some cancer, whatever. When they're afraid of whatever, I know those kind of patients. I know already, just by talking to them, if I have to talk to you first. . . . But the other nasty patients, it's because automatically, that's the way they are. You can tell, the way they talk to you (Luciana, personal interview, February 18, 2013).

While dealing with difficult or violent patients requires one kind of emotion management, controlling one's own emotional reactions while trying to work with patients to control their actions, working with dying patients requires a different kind of emotional control.

Dying patients. CNAs sometimes have patients who are near death, and while this can be distressing for them, they feel keenly responsible for comforting patients who are at the end of their life. As Luciana said:

So many times people have been alone, older ladies, nobody around and they're dying. Guess who's there? We're there holding their hands. We're the ones there making sure that they're okay, you know. They're scared, nobody's there. Guess what? We're the ones there, because we care (Luciana, personal interview, February 18, 2013).

When patients are nearing death they often have family around them, meaning that CNAs have to take care of family members as well as their patients. Like many of the interviewees, George said that he aimed to give good care all the time, and was surprised when patients or their families felt that he had gone above and beyond what they expected, as with his care of this dying patient:

The mother was close to her death bed. . . . When I first started working with her in that week, she was well alert and she needed help with a lot of things. . . . Of course, I just did my normal thing when I just came in there, introduced myself, gave them exactly what they wanted, what they needed, as much as I can basically that's in my power, and that's all I did. And apparently to them, that's just a lot of things that they've never seen other people do. So it was to the point where the mother was close to her death bed and she passed away. The one night when she was still alert, the mother was saying, "Thank you so much" and her language was Spanish. I kind of understood what she said, but her daughter was there to translate. And she started tearing up, and then the daughter started tearing up, and they were both saying, "Thank you very much for all your help and everything you've done." And apparently the daughter went a step further in thanking me by answering me in the employee of the month thing. So I figured it was her because . . . they said . . . a patient's family member nominated you. . . . I didn't necessarily give anything extra, it was just a normal thing that I did. Apparently, it was just really good (George, personal interview, June 4, 2013).

Like George, Alex found that the best way to cope with dying patients when relatives were around was to behave calmly and professionally, and be present for the family:

I just had a night shift, and this patient was DNR and the family was in with him. . . . So, all of a sudden I get called in, a family member comes in and then he's just, like, I think he's stopped breathing. So I go in there, I just took one look at him and, like, he's gone, but you know I just did professionally, you know, I just checked his pulse and everything like that. There was a stethoscope there, I took it and try to hear for an AP pulse, and I just said, "The nurse will be in, I'll be right back, okay." So I got the nurse and he came, and I just told the nurse, like, that the patient had expired. So he went in right away. And the whole thing is to keep all the family members and patients comfortable about it, and reassure that there are

people watching them, taking care of them (Alex, personal interview, January 15, 2013).

While having patients who die in your care may be sad and stressful, it is a relatively common experience for hospital staff, and is usually expected. They can fall back on their experience to manage their emotions. It seemed from the interviews that violence was much more difficult to deal with, because it often came out of nowhere, and required instant emotion management.

Conclusions

Because of their role as providers of personal care, CNAs have a relationship with their patients that is different from that of other staff in the hospital, whose patient contact is generally for specific therapeutic purposes. While there is frequently a class difference between patients and medical and even nursing professionals (Chambliss 1996), nursing assistants are able to mediate between the often impersonal and technological aspects of hospital care and treatment and the patient's expectation not only of being "taken care of" (instrumentally) but also of being "cared about" (affectively) (Abel & Nelson 1990). The time that CNAs spend on personal care is an opportunity to talk with patients, both about medical and non-medical topics. This is essential to their work, allowing them to build trust, to mitigate the discomfort patients may feel in having strangers provide intimate care, including bathing and cleaning, and in helping patients to feel relaxed. This also makes it easier for other hospital staff to work with the patients.

Many CNAs describe their job as "making patients comfortable," which they define as giving them both physical care and emotional or even social care. This more holistic view of patient care is different from the emphasis on medical care in hospitals,

and may be because CNAs are prohibited from giving medical care by their scope of practice. In physical terms they try to make sure that patients are clean, warm, get the food they need (or are allowed) and are in as little pain as possible. In emotional and social terms, this can include listening to their concerns and fears, joking with them, providing what they need to feel at ease, and even giving them clothes. The holistic view of patient care resonates with Foucault's concept of "pastoral power," or nurturant power, where CNAs take on responsibility for care of the whole individual by knowing their particular characteristics and personalities, and providing personalized care based on that knowledge. This can sometimes be coercive, as when patients are persuaded to cooperate with care when they are unwilling, but is based on the belief that the CNA knows what is best for the patient.

The frequent use of family metaphors in describing the CNAs' idea of the gold standard of care emphasizes the importance of both instrumental and affective care to them. Cold efficiency is seen as insufficient, and patients often react badly to this kind of attitude, so it seems to be important to them, also. The ideal of giving the kind of care that CNAs would want for their own family, incorporating both instrumental and affective care, corresponds rather closely to the idea of the maternal role in the family; family is where you learn emotion work and emotion management (Hochschild 1983). However, while this orientation can result in infantilization of patients in nursing homes, this attitude was much rarer among the people I interviewed, although it occasionally emerged when some CNAs talked about patients with dementia or confusion.

Professional workers in medical settings are taught that detachment is the correct stance toward patients (Cancian and Olicker 2000; Chambliss 1996; Diamond 1992, Misra

2003; Rakovski and Price-Glynn 2010; Stone 2000). However, CNAs usually resist and contest these professional norms, seeing detachment as an inferior form of care, and even in opposition to “real” care (Foucault 1990; Stone 2000). The work of CNAs by its very nature involves interactions between patients and workers, with the expectation from patients and families that the quality of that interaction will include not only proficient and efficient performance of care tasks, but also a caring attitude, as in the old saw, “doctors cure, nurses care.”

Discussion of affective care, emotional labor and emotion work is not part of the CNA training, and is not generally explicitly mentioned or valued by employers, including at Northside Hospital. There is little or no instruction or direction towards (or against) the emotion work of “caring about” in either the training or the management of CNAs in hospital settings. However, CNAs themselves see this as important. Two possibilities (which are not mutually exclusive) follow logically. First, that the recruitment of CNAs takes into account a caring disposition as one of the requirements without explicitly requiring it, so CNAs bring this disposition into their jobs without it being externally managed (Wharton 1993). Second, that it is something that patients and their families expect, and their emotion work produces a particular set of emotions in the workers (Lee-Treweek 1996). It could also be that hospital administrations genuinely do not care if their CNAs have a caring disposition, but given the importance of patient satisfaction surveys and other bureaucratic quality control measures, this seems unlikely. The fact that patients nominate CNAs for employee of the month or mention the excellent (or not so excellent) care they receive suggests that a caring attitude is important to patients, and thus to management. It seems most likely that employers simply assume that

members of the nursing team will project a caring attitude as part of their work, and that they select workers who embody those characteristics. Since in this study I only interviewed CNAs, I have no evidence for what employers select for beyond the bare job advertisements, and can only say that the CNAs treat their emotion work as innate rather than externally directed.

In some contexts emotion management becomes more explicit. While one might expect that dealing with dying patients would be traumatic for CNAs, these occurrences are generally expected, and CNAs know how to deal with them with compassion and professionalism. They often derive a sense of satisfaction from helping patients through their final hours and supporting the family. Incidents of violence are the most difficult to deal with, since they often come out of nowhere, even if the patient is known to be violent. The shock of assaults, combined with the need to take action to calm the situation and to invoke empathy to minimize the responsibility of the patient for such assaults, requires a considerable level of emotion management. While there are procedures in place to deal with violent patients, CNAs are at the frontline for assaults, and the procedures generally follow an assault rather than prevent it.

Somewhere in the middle of these two situations is that of dealing with difficult, uncooperative or abusive patients. In these situations, CNAs follow strategies either of withdrawing the affective elements of care, and invoking professional detachment (which, as previously discussed, is seen as a hallmark of inadequate care), or being even more caring and kind, in hopes of changing the patient's attitude. In residential care, boundary work is used to categorize residents as "lovelies," deserving of both instrumental and affective care, and "the disliked," who receive only instrumental care

(Berdes and Eckert 2007; Lee-Treweek 1996) and these categories are maintained and even institutionalized. In the case of hospital care, strategies of “being professional” or “killing them with kindness” are not based on a categorization of the patient (since they apply only to patients who are already seen as difficult or uncooperative), but on the orientation of the CNA, with a possible gendered element. For male CNAs, keeping one’s cool may take precedence over winning over patients, although in their routine work male CNAs seem to have just as empathetic an attitude as female ones.

As hospitals have become more technological, and RNs’ professional aspirations have largely taken them away from bedside nursing, CNAs now fill the role of “the angel at the bedside” providing the “human touch” that is appreciated by patients, even if it is undervalued by hospital administrations.

Chapter Five looks at the career trajectories of CNAs. Few of my interviewees started their careers planning to be CNAs. Some planned careers in healthcare, such as nursing, but found they could not complete their training due to life events like having a family. Some continue training incrementally, combining work and school until they achieve their planned goals. For others it was a career change, often motivated by a desire to go into a caring occupation after an experience with friends or family in hospital.

There are no real career ladders for nursing aides unless they become trained and certified in another healthcare occupation, which requires a much greater investment in time and money. On-the-job training, such as the cross-training discussed in Chapter Three, is not accredited so is not transferrable if the CNA changes employers. The next chapter discusses these issues and suggests some policy implications that arise from this study.

CHAPTER FIVE

TERMINUS OR WAYSTATION? CAREER TRAJECTORIES OF HOSPITAL CNAS

When I first became interested in the work of CNAs, lying in a hospital bed being treated for cancer, one of my initial questions was whether the job was a terminal occupation or a stop on the way to another job in healthcare. The answer to this was complex. Few if any of my interviewees had started out their working lives with the ambition to be a CNA for the rest of their lives. Some started out planning a career in nursing, but “life got in the way,” often meaning that they had a child at a young age, and could not complete their training at that time. Others started out with jobs that had nothing to do with healthcare and a particular circumstance changed their plans, often involving contact with hospitals or a desire to help people.

The other end of this career trajectory is where people plan to go in the future. Many of those I interviewed were in college, or had plans to start or continue in the immediate future. They were often juggling two, or even three, balls, working full-time, going to school and often caring for children on top of that. Their path to further education and credentialing was often an incremental, dynamic, stop-start affair over many years. I have not been able to find a literature on this kind of studying, since the assumption is usually that if someone stops their education before completing their course then they have dropped out, rather than that they are taking a break and will pick up again when finances or circumstances allow.

As noted earlier, CNAs in hospitals have more education, on average, than those in other settings, and have higher pay and benefits, including a greater likelihood of having tuition support for education (Yamada 2002). Nationally, almost half have some college education beyond the CNA training, compared to less than 30% of aides who work in nursing homes (Yamada 2002). My interviewees at Northside far exceeded this profile with only two, both women over 60, having no college education apart from CNA training. In addition, eight (38%) were combining work and study at the time of the interview. It is possible, however, that these figures are not representative of CNAs at Northside, since those involved in study may be more willing to be research subjects. However, Northside Hospital provides structural incentives for higher education by providing tuition benefits for full-time staff. Benefits are capped at \$2500 per year, which covers eight to twelve credit hours (three to four classes per year) in local public community colleges, more if students are in-district.

Career Ladders within CNA Occupations

Concern over staff retention in nursing homes has led to some attempts at creating career ladders in individual homes by providing additional training and promotion within the occupation, but, like the cross training at Northside, such training is unaccredited. This means that it serves the institutional needs for improved patient outcomes, and provides some job enrichment and a little improvement in salary, but is not transferrable (Moffatte, Stefanini and Hardke-Peck 2000). In addition, while nursing assistants may be promoted into supervisory and management positions in nursing homes, this is not the case in hospitals, where they are at the bottom of a steep hierarchy of occupations with more education and prestige.

There are signs of accredited pathways to enhanced CNA practice; however these are not widely accepted at the present time. For example, Oregon has introduced a level 2 CNA certification in acute care, allowing CNAs to take on additional tasks such as dressing wounds, which may be a way of replacing the loss of LPNs in hospitals (Oregon State Board of Nursing N.d.).

Another potential pathway for advancement for CNAs is as a Certified Patient Care Technician, which is a nationally-recognized certification obtained through examination (National Healthcareer Association, N.d.). The competencies for this certification are the same as those for the certified nursing assistant, with the addition of performing EKG tests and phlebotomy, and at least two of the interviewees had completed this certification (Teddy, personal interview, May 18, 2013; Charles, personal interview, June 18, 2013). There are some training courses that prepare students for this certification, including private and community colleges in Illinois. While private colleges typically offer courses that include the CNA training, and are considerably more expensive than the basic nursing assisting training, community colleges offer the training as an advanced class for those already holding the CNA certification, and cost less than the basic certification (Triton College 2014; Truman College 2013).

However, it should be noted that the use of the term “Patient Care Technician” is by no means unambiguous. The PCT seems to be a job title that started in the 1990s when hospitals were starting to remove LPNs to peripheral services and wanted generic care workers who could perform some technical tasks. In some cases, it is used interchangeably with nursing assistant (certified and uncertified), while in others it refers to CNAs that have additional, but not always accredited, training and duties. The job

description and scope of practice for the PCT would appear to be becoming more fixed, particularly with the introduction of a national certification, but there is still a great deal of inconsistency in the use of the term, the training required and even whether hospitals employ staff with that title.

Findings

Since this chapter is examining the career trajectories of the CNAs in the study, I have looked at the individual pathways of each interviewee to give a sense of the factors involved in their decision-making processes. There were some commonalities in different pathways, so I have looked at two parts of the journey and broken each down into different analytic categories. First, I look at how the interviewees became CNAs, including the previous occupational histories of those who went in nursing assisting as a second career. Second, I look at the next steps, focusing on those who are in college or planning to start shortly. While I focus on their immediate goals, I also mention the longer-term goals that some of the participants expressed.

Routes to Becoming a CNA

Unsurprisingly, people who become CNAs tend to come from working-class families, and many of my interviewees were also first or second-generation immigrants. Many worked even in high school, often in food service occupations. Even those interviewees that decided early that they wanted a career in healthcare did not, for the most part, consider full-time education after high school; the CNA certification was a fast, low-investment credential that allowed them to work while, in some cases, continuing their education. Another group became CNAs as a second career, sometimes after a period spent raising children.

Straight from high school. Some of the younger interviewees had planned to go into nursing but chose to work as CNAs in the meantime because they needed to contribute to the family finances, and for an initial low investment in time and money they could earn money while pursuing their nursing training. In fact, it seems that many LPN and two-year RN programs include the CNA certification in the early stages of the training, or require it as a prerequisite. Introductory nursing classes and 40 hours of clinical supervision are acceptable in place of CNA training courses as a requirement before taking the written certification test (Illinois Department of Public Health N.d.a). Anne is one of the interviewees who took her CNA certification as part of a nursing course.

Anne's family emigrated from India. She is 19, single and lives in a condo with her parents and her married brother, who is shortly to be joined by his wife from India. Her parents are unable to work due to health issues, so she and her brother are the family breadwinners. In high school Anne worked in the kitchen of a nursing home, then as an activity assistant while starting her nursing training:

At a young age I knew what I wanted to be. So right from high school I went to college. Seemed when I did my college I did my CNA. So I did both at the same time. I'm still in my nursing school. Right now I'm in [Community] College, but I'm going out of state, so I'm going to [A State] College (Anne, personal interview, June 18, 2013).

Northside is her first job as a CNA, and she explained why she chose to work while pursuing her education:

The main reason why I became a CNA was . . . I had financial problems going on in my family. So if I can give them an extra hand, you know, to make everything smooth, I will. Anyway, I have to spend four years to be a nurse- it's like three months and you can do something that pays off good. And I always like to deal with the people. So I thought, yeah this is going to help me out. I could be a

pharmacy tech but I'm not dealing with patients that much, or people that much. But I prefer to be with people than just staying behind a counter or sitting somewhere (Anne, personal interview, June 18, 2013).

George planned a career in nursing straight out of high school, and the college required the CNA certification as a prerequisite for the course. He decided to get the certification at a cheaper place before he started:

[After high school] I was going to [Local] Community College and I was taking my pre-requisites for nursing and then one of them was saying you got to get the CNA, so to have a certificate my friend suggested that, "Hey, instead of going to school here to get the—I know a place that charges a whole lot less and we can just get the paper" George, personal interview, June 4, 2013).

Two interviewees had started in a nursing course, but had not completed it because of early pregnancy. Becoming a CNA was a way to continue in nursing care, since they already had the training. Melanie, a 23 year old single mother who has worked at Northside for four years, started training as an LPN while still in high school:

My sophomore year, I enrolled in the LPN course. I graduated and was supposed to go back for my exam and got caught up in life, and I guess I was just really happy at the time, so I just never went back for the test, so I ended up a CNA. I don't get paid as much as I thought I would, but I don't regret it. I think if I would have gone on starting out as an LPN, I probably wouldn't have enjoyed it as much I enjoy my job now (Melanie, personal interview, May 30, 2013).

In fact, Melanie found out she was pregnant early in the course and planned to drop it:

For the first semester it was a little challenging because I was pregnant with my daughter, so I think that's why [the nursing instructor] hunted me down. I actually applied, but I didn't know that I was pregnant at the time, and when I found out, I said there's no way I'm going to have time and I'm not going to waste someone else's time and devotion to try to get me that kind of education, when I don't know what I'm in for yet. . . . So she kind of followed me and I told her my situation and she said that that was even more reason to get enrolled and got me started. . . . And I had my daughter, so I kind of missed the first, the basics, the CNA part of nursing. . . . Once I had my daughter, I was back five days later because it was a requirement. . . . [I] caught up with all my testing, my workbooks and everything and just kept going. But the first year, I got my CNA- . . . it's one of the steps. That was good because . . . I got something out of it, even though I didn't get what I worked for (Melanie, personal interview, May 30, 2013).

Melanie had completed all the training to be an LPN, but did not have the license, which made it complicated when she started as a CNA, and did not realize that she was not permitted to do many of the procedures that she was trained for:

When I started working as a CNA, I didn't know anything, like when people ask me, "Oh, what do you need for your CNA?" I have no idea because that's not what I originally went for. I literally had to be walked through what I can and can't do by my manager because we are allowed to do IVs and colostomies and tube feedings as an LPN. So she said, "You can't do that," so I kind of had to go back and make sure I knew where I stand as far as my job, because I didn't want to cross anyone. So that was a little difficult, but I love my job (Melanie, personal interview, May 30, 2013).

Elena is 30 years old. In high school, she wanted to be a doctor, and at 17 she was awarded a summer internship in a hospital as part of a selective program across the city's schools. She was placed in a surgical intensive care unit, and found the work exciting, particularly as a famous basketball player was in the unit and there were reporters trying to gain access! However, she also experienced the serious aspects of hospital work:

To see somebody die, the first time for me, was just, emotionally too hard, oh my God, to hear family cry like that. And especially, the mother only spoke Spanish, and nobody else really spoke Spanish. They asked me, "Can you interpret it with us?" Usually somebody there in the hospital can, but it was late, they asked me to come in, and I was just, like, this is too much for me you know? [Nervous laugh] . . . After the internship was over, . . . I told my mom, like, "Really mom, I think I wanna do nursing," and she was like, "Why? You always wanted to be a doctor." My dad was just, "What! Be a doctor!" But I said, "No dad." Yeah the doctor's great, the name, respect of a doctor but I liked how I got to interact with the patients and learn them (Elena, personal interview, December 3, 2012).

She started a nursing degree: "I started school [for nursing] after high school [laughs]. But, uh, life happened, I got married and had three kids, then I stopped for a little bit" (Elena, personal interview, December 3, 2012). She has worked as a CNA since then, with experience in three different hospitals and in home care, and some breaks to raise her children, before starting at Northside Hospital.

Sofia is 32 and single. Her initial desire to be a nurse was dampened by her experience working in a hospital, and she dropped her nursing course for an associate's degree in science, then gained a second associate's degree in business. However, she carried on working as a CNA:

So I have two college degrees, two associate's. I first wanted to be a registered nurse. So I went to school for that and I didn't finish nursing. I thought . . . I don't want to be a nurse because I am working part time in a hospital at a medical surgical unit. That kind of took that dream of being a nurse away because it was so different. It was like I was just picking up poop all day and dealing with nursing home patients. So I decided I was just going to get my science degree . . . and I said if I change my mind at least I have that. And then I decided to get a business degree. So I went back to school and I was still working at the hospital part time (Sofia, personal interview, June 13, 2013).

Laura is 23 and single. Her mother was a nurse, but she was put off the idea of going into nursing herself, because she saw how stressed her mother was from her work. Like Sofia, she decided to take business classes:

Once I graduated [high school] I was going for it and I told my dad I'm going to for business and marketing. And we already had it planned out that I was going to go to [Local Private University] after I get my two year pre-reqs and stuff like that. And now . . . he's like, "I thought you were going for business? What happened?" But . . . I stopped the first year and then I just stopped going to school for a year. . . . I went back into school little by little (Laura, personal interview, June 11, 2013).

After she dropped out of college, Laura's mother encouraged her to take the CNA training:

So she was the one that said, "Just go in there. Just, can you for me? Can you just go and try it out and see if you like the classes. See, they're going to do clinical and see what you like. If you don't like it, you can just drop the class and you know nothing happened." So the first time my mom paid for the class. I went. Like I said, it was my last week of clinical. I said, "I don't want this." I just dropped the class. So, pretty much, it was like my mother's money was gone, . . . just wasted. And then . . . I thought about it. I said "No, I really like this." . . . So I went back for it. . . . So I was paying for it. I was working full-time at Little Caesars. I was going to school for this and it's like, "Oh, my God. I did this to myself, when I could have been out a long time ago." So that's why I like

thinking of the stuff that I do at work. It's like, "Oh, I'm doing it the same way my mom used to do it to me." Do this first and then, you know, maybe you can do that later. So I've been on my own since I'm 17. So I guess that's why also she wanted to make my life easier. You know, it's better money here but you also learn here (Laura, personal interview, June 11, 2013).

Leah is 25 and single, and lives with her parents. She has worked from an early age, since the family needed her financial help:

I was working before. I've always cleaned, since I was young. I love cleaning. I used to clean family friends' houses, whatever. You know, when you're young, you always try to make money. Then I got lucky, I got my first job, I worked at a bakery down my street. Great lessons too, there [laughs]. You know, I had a boss who would tell me, "You have two hands – use them." You know, work quicker! I mean, it's like, \$7 an hour, what do you want me to do? Shut up. You know, I'm dealing with customers, that was my first, like, relations. Then I worked in a senior living facility serving in the dining room. That was what I was still in high school. I did that. I worked in Bath and Body Works part-time. Oh, and then I worked in Steak n Shake for a little. That was the fast food, you know, you learn that too, it's like [laughs]. I mean, that's more customers, like, nonstop, it's like – it's work! (Leah, personal interview, February 11, 2013).

Leah decided to become a CNA in high school, but always had the idea that she would train as a nurse eventually. She took a class at a school that also had an agency supplying staff for home care, but grew tired of the intense relationships and moved into hospital work:

You know, this girl at my school, we were just sitting there one day and she's, like, "Yeah, I found this flyer" – it was for [Local Community College] – she's like, "For nursing assistants." She's like, "I'm gonna do this, you know . . . you can make like, \$10 an hour." I'm thinking in my head, like, this is great. Like, I've gotta, like, come out of high school. I gotta start somewhere. And I'm thinking, what can I do? Nursing, why not? You know I've always liked taking care of my family and, like, why did it never dawn on me? So it was like, oh! One of those moments for me, just like, wow, you know. That's what you want to do. . . . So then I went . . . to a small little CNA school. It cost like, \$600. It was, like, 4 weeks program. I had no clue what to expect. I did home healthcare first, for the school – they had a company. You know, my two clients got really attached to me and I wasn't making that much money. And I was just ready to go to the hospital and, you know, just not get so attached, cause these people just want YOU [laughs]. They want the life out of you. Like, please, I'm not your servant! I left them on good terms. I worked at [Another] Hospital for 5 years. Same hospital

setting, you know (Leah, personal interview, February 11, 2013).

Maria's journey to becoming a CNA is more complicated than most of my interviewees. She became pregnant at 16, and married her daughter's father at 17. She subsequently had 2 more children. She is now 35, and her marriage has been shaky, but her husband recently moved back in with the family after their most recent two-year separation. She decided to move into healthcare while working as a receptionist at a clinic:

I worked at a clinic at infant welfare society. I started off as a receptionist, but I'm like, wait a minute, I could be a medical whatever. So it got to the [point] where I got laid off there. So I'm like, you know what? I'm going for school for Medical [Assistant]. . . . At the place where I was at, which I still keep in touch with the coworkers, they're like, "You are a Medical Assistant? You should come and work." Like, no! You guys laid me off, I don't think I'm gonna go back to you guys. You guys never needed my service, so now I'm doing a little bit more (Maria, personal interview, February 11, 2013).

She graduated with honors as a Certified Medical Assistant, then worked at a health center:

So, I'm a registered Medical Assistant. I worked at a low income family health center for five years. I started as a Medical Assistant, then I worked my way up to, um, to work with OB, and, it's a family practice so I got to work with children, adults, elderly and OBs. So I got a variety, I mean, it was amazing. I still keep in touch with all my coworkers at there. And I worked also as case management assistant, so I helped the case manager get all the charts prepped for the pregnant ladies and make sure they reviewed. So it was very interesting how I was the one sitting there and helping them and getting referrals and – which was very nice. But I got to the point where I'm like, no, no, no. I don't like office, I can't. It was very depressing. I have to go back with my patient care (Maria, personal interview, February 11, 2013).

A patient told her about a not-for-profit that provided free CNA training to low-income candidates, and since she had recently separated from her husband she qualified. This was an unusual move, since becoming a CNA would be seen as a step down from a Certified Medical Assistant, which requires longer training. She was hired as a CNA at

another hospital, and worked there for 2 years:

And when I went for my first, at that [other] hospital, where I took care of more vent patients, it was very depressing, because I didn't know what was wrong with them. . . . And I worked with nurses who were – I could say – careless? I don't think they were careless, but just, the care wasn't that great. I'm like, "Oh, this patient is dead." So I ended up learning, like, getting their bad side . . . and it was very negative (Maria, personal interview, February 11, 2013).

She left that hospital, and applied for other jobs, including at Northside:

I just wanted to leave the hospital, I didn't want to work there anymore, because it got very depressing. I actually applied as an administrative assistant [at a counseling center for homeless youth] because I knew receptionist and I knew case management. . . . So, I started work, and my first day there I got a call from Northside, "Are you still interested?" I'm like, "Yes!" [Laughs] . . . So I did both at the beginning, when I started working two years ago here. The funds finished for that one, and then I stayed here full-time (Maria, personal interview, February 11, 2013).

Maria is much happier with the care provided at Northside than at her previous hospital:

I'm like, wait a minute, it's not the same. This is heaven here! So my attitude started changing through that. . . . So I always, if I have any negatives I was like, no, wait a minute. This is a good one (Maria, personal interview, February 11, 2013).

While most of the CNAs I interviewed did not start out on a traditional route to higher education, two of them had started at four-year universities, with the intention of pursuing a professional career in healthcare. Despite a considerable investment in time and money, both had failed to graduate, because they did not complete the requirements for a major. Becoming a CNA was a way to keep their feet in the healthcare field while deciding on their next move.

Dropping out of university. Graciela is 38 and married, with 5 children under 18.

After high school she attended a university nursing school:

And I stopped doing all [that] because I started extracurricular. . . . My second year at [Private University] I became an officer of the Filipino Club and they also asked me to choreograph the Filipino portion [of the International Festival] and I

loved it. That's my arty side. . . . My mom is a nurse and I grew up with that kind of setting. If I thought I could do it, I would have probably gone into like architecture, interior design because I love creative. I stopped studying as well as I should and that's why I went and started to consider psych, which I stopped again. My first two years I went full-time and then my next four years I went part time. And I worked full-time at the same time. And I was single. I was an official psych major. And then I stopped because I'm like - and what's frustrating was that I stopped one class shy of Bachelor of Science and Psychology. But it was getting too expensive anyways (Graciela, personal interview, July 18, 2013).

After her marriage, Graciela worked as a waitress, taking only a few weeks' leave for each child. She enjoyed the work, but not the pay and lack of benefits. Eventually, she had a "now or never" moment and decided to return to nursing school, working as a CNA while attending college:

We had one and I was pregnant with my second. Then we had our third. My youngest boy, that's our fourth boy. That's when I knew. I'm like, I can't wait any more. We have a big family and I really need to do this for them and for my own self. . . . I got [the CNA certification] right before I started the pre-requisites. So I think, say, 2006. I was pregnant with my youngest boy. Funny enough he also went through CNA School with me. And so I was getting bigger and bigger as I'm trying to pass. . . . And it was only in summer but you had to go like Monday through Friday, and Friday was your clinicals, as I'm getting bigger and bigger in these white scrubs. It was so funny. It was a good experience (Graciela, personal interview, July 18, 2013).

Charles had also attended university. He had declared a number of different majors, including pre-med, but, again, did not graduate:

I started college in fall of 2006, I was there for four and half years, this was in Florida. I had three majors and did pre-med, left in fall of 2010 and then have been trying to figure out my next education stuff ever since, taking classes and certifications. [I trained as a CNA] back in my home state . . . through the American Red Cross, one month of training and then three eight-hour shifts in a nursing home. Took my test probably two months later, in July made an intern. But over that time I was working and once I got my certification, within about a month, I had two job offers, one was PRN [as needed] one was full-time. . . . Then I worked for a full year as a CNA. (Charles, personal interview, June 18, 2013).

He had initially thought about becoming a Physician's Assistant, but chose to be a CNA

because of the short training. After moving away from home, he was offered a job at Northside, where he has worked ever since.

While many CNAs decided on a healthcare career straight out of school, others came to it later, after another career or after raising a family.

Becoming a nursing aide as a second career. The CNAs who came to the occupation as a second career had mostly worked in clerical and other pink collar occupations. They fell into two age groups, and this often affected their decisions concerning future training or career progression. The older group had spent time raising children, sometimes staying at home, before deciding to train as a CNA. Some of them had thought about pursuing nursing training, but felt that it was too late for them, and that they would rather support their children in their education than put the necessary time and money into their own training. Daphne is 48 and married, with two children still at home:

After high school, I went for one semester in college and I enrolled into beauty school and it was okay. I mean, I did that for a couple years, but I wasn't, I found it was more of a hobby than [laughing] actually pursuing a career. And then after that my girlfriend introduced me at this job at a private investigator firm to be like a private investigator, but working in the office, as taking information from . . . employers that are seeking and hiring employees as far as the airlines, the trucking industry. . . . [Y]ou know, where they have been for seven years? How was their work before they have been terminated? Security checks as far as, you know, they have any felonies or something, drug testing and stuff like that. So involved in a lot of paperwork. . . . I did that for 11 years, until after 9/11 they started to lay off a lot of people. So they started going from seniority down. So they let me go (Daphne, personal interview, July 2, 2013).

By this time Daphne had married and was trying to start a family. She had two miscarriages, which she put down to the stress of her job. After she was laid off she had her first child and her husband suggested she stay home to raise her family:

And then my husband's like, "You know, just stay home and just raise the kids up to a certain age where they . . . can go to school full-time and then you can go and

look for something.” And in the meantime I was just all about helping people, because I guess being a mom myself and taking care of my kids and doing all that. . . . My grandmother, she's like 98 years old and I kind of helped her at home. So I kind of had the feel of it, you know, helping her to the washroom. My grandfather, God bless his soul, before he died, helping him out and helping him eat and stuff like that. So I got the feel of it and I'm like, yeah I think I'm beginning to like this. So that's what kind of encouraged me to look into the CNA and patient care. And I was hoping maybe go back to school and pursue something else. . . . I really don't have the money to do that right now. I would love to, but I think age is a factor (Daphne, personal interview, July 2, 2013).

Daphne works in the maternity unit as a Scrub Tech, and loves it, but realizes that the only chance for further progression would be to train as an RN. However, she feels she is too old and that it would disrupt her family life:

I mean, I want to stay in that department and the best, the only opportunity can arise is going for a registered nurse, you know, and you're talking maybe six years until I complete that -. . . I'd have to do everything from the beginning. By then I'll be like 55? So I don't know. I kind of like where I'm at right now. It kind of works for my husband and my children and it kind of works for us right now (Daphne, personal interview, July 2, 2013).

Isabella is 61. She immigrated to the United States with her family as a teenager, and married soon after she graduated high school. She had 4 children, divorced her husband and raised them as a single parent, with a lot of childcare support from her mother. She was on welfare for a short while before training to be a CNA:

Then I got married, I had my kids. I didn't work for many years and then I decided I wanted to do something. . . . I am a people person, I need to help people and I wanted to be an RN, but going to school, I tell you what, I never did it, because I got involved with my kids and I never did it. So I've been working as a can. . . . We both always wanted, “Let's go to school, let's go to school,” but we never did. Actually, we went to enroll but I don't know what happened we never went back (Isabella, personal interview, July 18, 2013).

Luciana is 51. She married young and had a family, but has been divorced for many years. Her 2 children are adults, and she has a teenaged granddaughter. She has lived with her current partner for 17 years. After leaving high school, Luciana went to

community college for almost two years, but she already had children and left to work in a bank, although she had early dreams of being a psychiatrist:

I wanted to be a psychiatrist, but then with my children- I already had children and everything- I didn't have no way of getting to school or nothing, so I was at the bank. And it was nice. I used to dress nicely, I was keen, and I was very full of life and everything. . . . And then I said, "Oh, I wanna be a nurse. I wanna take care of people. . . . I'll go to do my CNA and then I can go and do for my nursing." I was already 34, 35. . . . My children were already grown up, I didn't have to be behind them, or anything. I said, "Okay, I can go to school." I did my CNA, I started working, and I said, okay. I even registered to start taking classes, to go for RN and everything. And there comes my daughter pregnant with a child and everything. I'm like, you know what? I have to dedicate myself to her. So my life went with them. So I didn't finish. I said, "Oh, it's okay. I'll stay as a CNA, I'll make the best of it," and that's what I've been doing (Luciana, personal interview, February 18, 2013).

Luciana's daughter's teenage pregnancy made her sacrifice her own aspirations to be a nurse, and she put her family first, helping to raise her granddaughter.

Sandy, at 64, is the oldest CNA that I interviewed. She raised her three children as a single parent and, like Luciana, one of her grandchildren, since her daughter was pregnant at 14. She is now a great-grandmother. She did not have many educational opportunities in her youth, and was expected to take care of older relatives and neighbors. It is a source of pride that her children were all able to get the education she could not achieve. Sandy has been a CNA for 20 years, but before she took the training she worked in a nursing home as a cook:

Well, the way I got trained . . . I was working in the kitchen in the nursing home. Then I seen these CNAs and I asked them, I said, "What do you do?" She said, "I'm a CNA." I said, "What does a CNA do?" So- which I kind of knew about because I've taken care of family members since I was small. And I said, "Oh, that sounds like a good deal." So she was telling me what you have to do, and you have to go to school. The program I took was for 9 months, and I got certified. . . . When they send you to get your CNA license, you are contracted with them. You have 6 months, a year, 5 years. Well, I was working there anyway. So I worked there about 5, 6 years (Sandy, personal interview, February 14, 2013).

Sandy appreciates working at Northside, because for the first time in her life her work is near her home, a rented apartment that she shares with her partner of many years. This is particularly important now, because her partner was recently diagnosed with Alzheimer's, so she has to care for him after her workday ends. She also appreciates the benefits that come with the job, now she is older:

All of my life, the places that I worked, I've lived across the city from where I worked at, and it just so happens, I guess God is opening up for me as you get older, it's very comfortable for me now. The pay isn't as much as I should have, but sometimes you have to weigh the different things [like benefits]. . . . You don't think about it till you get older, which is important. It used to be money, but not any more! [Laughs]. I'll probably keep on as I retire, too. Because it's in my system, cause I don't think I'll be able to stay at home, just stay at home. Cause, after you clean the house, what is there? And you don't have kids, so you don't have to cook all the time [laughs] (Sandy, personal interview, February 14, 2013).

Yolanda is 40, married and has four children under 18. Straight after high school, she went to college and gained an associate degree as an executive secretary:

I worked in a consulting firm, . . . they went to businesses and gave them advice on how to make more money. I worked in the sales department and I also worked in the customer service. I worked in this other construction firm, also clerical, and then I found this, Northside (Yolanda, personal interview, June 13, 2013).

It was having a baby at Northside that prompted her to apply for a job there:

I didn't know that this other part of my life I have in me until one day when I had my baby. I had it here, Northside, I loved the care, I loved the doctors and I said, what I really want is to work here. . . . Now that I look back, I was very miserable. . . . I thought I was really happy in the jobs that I've had before but little did I know that now is when I'm very happy at my job. Now is when my true calling that I didn't know, it just led me here (Yolanda, personal interview, June 13, 2013).

She applied regularly for two years for clerical positions at the hospital, and eventually was hired as a Unit Secretary. When the hospital abolished those dedicated clerical posts, she was told she would have to train as a CNA, and the hospital paid for her training.

Northside is the only place she has worked as a CNA. Like the others in the older group,

she has thought about training to be a nurse but, like Luciana, she has sacrificed her own ambitions to focus on her children's futures:

I've had a lot of thoughts and ambitions to become a nurse, but right now I have one daughter that's a freshman in college. I have another that's going to be an eighth grade, so they are getting closer and closer for them going to college. So right now my main concern is my kids. When I went to CNA, I wasn't home a lot and I studied a lot and I just felt like I neglected them a little bit and then at that time even my daughter Emily, she lost her two front teeth. My husband was cooking and she was playing in the patio and she fell on a scooter. I mean, that could have happened with me too, but normally like I would never let her alone outside even if it's in the patio, I always sit there with them. So I felt like right now, I think the best inheritance that I can give my kids are giving them values, giving them time and just trying to save up for their college (Yolanda, personal interview, June 13, 2013).

Teddy is another CNA who has been raising his family as a single parent. He is 56 and divorced, and has custody of his two sons, who still live at home. Teddy previously worked as a chef, but felt that his race meant that he was not being given credit and promotions for the work that he did:

I went to . . . Culinary School [in Britain] . . . for 4 years . . . I worked as a chef. And when we came to U.S., I still worked with [Atlanta Hotel] as an assistant chef. . . . I had a huge problem with the racial thing [in Britain] being black, especially to head a department. Both places that I worked I was just like the invisible chef . . . because the chef takes all the credit. . . . Every 3 months, I change the menus and everything about—he signs off and he gets the credit. When I came here too, I experienced the same thing working in Atlanta. . . . The whole kitchen was dominantly whites and when I was first introduced, people look at me like, “Who is that?” And some either take instructions or not. I do a very good job but also not noticed. So I decided to be on my own. And they didn't realize until I left because certain things wasn't the same anymore. Because I do all the dirty work and the chef come in and sits in the office and . . . I go around the kitchen instructing, supervising, doing this and doing that, ordering food and making sure menus are well planned and other things but it's just me (Teddy, personal interview, May 18, 2013).

Like Yolanda, it was experiencing hospitals at first hand that piqued his interest in a career in healthcare:

What got me into the nursing, my grandmother visited and we had a hardwood

polished floor. She slipped and broke her hip. So she was hospitalized and she keep complaining about not being there for her, they weren't caring that much. So I went in as a voluntary worker, so that I can take care of her, because they were not allowing me to be coming there every day. . . . And that is when I found the need that people really need. And then I said, "Okay, I can do this." And then one of the doctors said, "You're doing all these things for nothing? Take the CNA class and you can make some money." So I took a 3 months CNA classes (Teddy, personal interview, May 18, 2013).

He applied to another hospital to work in the ER, and was told that he needed to take the Patient Care Technician training before he could get the job:

So I went and I did it and I passed the test and I started working in the ER. So I worked there for like 6 years before I came to Northside and there I got to draw blood. I got insert Foley. I got take off Foley. I got to do so many things and that's what I love to do. I want to be that. I want to do it (Teddy, personal interview, May 18, 2013).

Teddy also has a catering and cake decorating business that he runs with his brother.

Working as his own boss means he can continue in his original career without being hampered by the racial discrimination he felt in his previous jobs.

While the older group of second-career CNAs had mostly given up on the idea of further training and career progression to focus on their families, the younger group had different plans. These women had no children, or only one, and were combining work with study, although not always in nursing or health occupations. I discuss their decisions about their future training later in the chapter, when I look at the next steps for CNAs.

Both Alex and Ruth are at university majoring in other subjects. Alex is 28, and recently got engaged. She shares an apartment with her mother and fiancé. She was interested in medical subjects from an early age, but she worked at a variety of jobs, including construction, before a family friend advised her to take the CNA training:

So I went into CNA. It was my godmother that actually said, wait, you should try this, and so she paid. . . . So she was the one that encouraged me to go these routes, to do the digging, do the research, because I didn't really get that much

from guidance counselors. It was the strangest thing, she knew everything there was to know about life, which was very odd (Alex, personal interview, January 15, 2013).

Ruth is 34 and married, with no children. She also had a number of jobs after school, mainly service and clerical jobs. She was a flight attendant in her early 20s, then worked as a clerk in a law firm, and for a not-for-profit helping low income people obtain loans to stay in their homes. She grew dissatisfied with office work, and a mentor and family friend who was a physician inspired her to go into healthcare:

I remember he came down to visit and he told, he sat me down for probably, like, two hours, and we had this really elaborate conversation, and he said, "If you really, really want to see if you really, really have the desire to work in that industry," he's like, "Become a CNA. Be a nurses' assistant because if you start from that position," he's like, "That's gonna show you, and tell you, honestly, if you have what it takes." And it's very accessible, in that you can get the training over with pretty quickly and, you know, get involved in that. Because [he] is like, "If you don't like what you see there, then you're not gonna like what happens the higher up you go." . . . And so then that's what I ended up doing (Ruth, personal interview, November 30, 2012).

Marta is 27, and a single mother of one child. She also started out in a white-collar occupation, with aspirations to be a lawyer:

I sold houses. I was in real estate. I loved the hours. You make your own hours. I mean, I get to wear clothes instead of scrubs all day. Everything is a tax write-off (Marta, personal interview, May 23, 2013).

A family health crisis got her interested in a nursing career:

My mom was in the hospital for diabetes. And I just got frantic because I'm very motherly. And that's what my friends call me. And I care about everybody's health. So when she got sick I wanted to know more. And one of my friends went into Medical Assistant. And I was like, I don't know if I want to go that deep into it yet. So I decided I wanted to do a CNA. It's short, fast. I get my foot in the door and if I like nursing then I'll go into it. And that's how it started. Yeah, because I wanted to be a lawyer. I was taking classes at [Local Community College] to go to law school. And until this day my mom says you just should have been a lawyer (Marta, personal interview, May 23, 2013).

There was a final group of interviewees who became CNAs because they were

immigrants who had overseas healthcare qualifications that were not accepted when they came to the United States. Like many of the other interviewees, the CNA training was a low investment way of remaining in healthcare while they explored other training options.

Immigrants whose healthcare qualifications did not transfer. James is 36 and divorced with two children who live with their mother. He trained as an X-ray technician in his native country, but found that his qualification was not accepted when he came to the United States:

When I came here, it seemed like the standard here is too high. They wanted us to do more and wanted us to go back to school and it seemed like I had to do all my subjects again and repeat all that you know (James, personal interview, May 21, 2013).

He got a housekeeping job in a nursing home where he became familiar with the work of CNAs and decided to take the training:

When I was here I just wanted to make some money, any kind of job. So I applied to a nursing home as a housekeeper . . . and then I heard about a CNA and I never really expected that that is what the CNA is doing. At first, it was too hard to, you know, just change diapers and I got kind of used to it and still once in a while, it gets to get me. I didn't really expect that this is what the CNAs do, until I started taking the class and there were teachers who were telling us, "Okay, who is going to change the diaper?" I said, "What?" And then . . . the room was "Oh" (James, personal interview, May 21, 2013).

Angela is 55 with two grown children. She is an immigrant, and trained and worked as an LPN in her native country. However, when she emigrated, she found that her English was not good enough to work as an LPN, although she tried to take the test. She was able to work as a CNA, though, and has worked for fifteen years in that role at Northside, starting off in the extended care unit before moving to wound care four years ago (Angela, personal interview, June 25, 2013).

While a few of the older CNAs had decided not to pursue further training and education, all the younger CNAs had plans to do so, and two-fifths of them were already combining work with part-time college classes. The next section discusses this in more detail.

The Next Step- Moving On from being a CNA

Northside Hospital did provide some support for combining work and study. Full-time workers are able to get tuition support of up to \$2500 per year, and Unit Managers were often supportive towards their CNAs, particularly those who were going for nursing, as Elena attests:

My boss is all about going to school, so she's very about like, "Advance yourself." Even though she is, like, "I don't want to lose you, but I know it's good for you." She will put in a good word for you, cause sometimes you need that recommendation letter. She does a really good job about that. And I think a lot of hospitals are like that, a lot of them are – because even my ex, he works out of a hospital, he's in school for architecture. But he was working in transporting as well, when I met him and he's finishing up his architecture – they paid for it, you know, for him to go. Even though it's not medical, but just to advance himself (Elena, personal interview, December 3, 2012).

The hospital shift system also provided the flexibility that students needed so that they could combine work with their college courses. However, working and studying still required a great deal of motivation and energy, so it was generally the younger CNAs, and those with fewer family responsibilities, who were able to take on this kind of juggling. As Charles put it:

You have to be absolutely self-motivated. Individual managers may encourage, I mean my manager has been wonderful about encouraging me to follow my professional career and wanting me to go further, and anytime I brought something up has always been willing to discuss, but I think that's more of a personal level than a professional level. I hear a number of other aides saying, "Oh, someday I'm going to go for this. Someday I'm going to go for nursing. Someday I'm going to go for this," and I don't see a lot of action. I know that's

sounds kind of critical, but it's the truth, versus a different segment of the CNAs who are in nursing school or who are focused, or who are training to get these things done (Charles, personal interview, June 18, 2013).

While the cross-training does provide job enrichment for CNAs, and sometimes gives them experience which they can build on by getting further training, because it is unaccredited it does not offer a route to promotion or much of a pay increase. CNAs recognized that the only route to a better job was to get further education outside the hospital. Sofia loved her work as a Scrub Tech, but recognized it as a dead end:

I think that because I work in labor and delivery and it's so specific, I got that opportunity to get that training to do the GYN cases in the OR. But . . . do CNAs have the opportunity to move up or to get training? I don't think so. I think it is what it is. It's the CNA and if they keep coming and going. So if they want to move up, they need to either go back to school or they need to go into nursing and I think that's . . . what a lot of the CNAs are doing now, they're doing CNA because it's the requirement for a lot of schools in order to do nursing. But it's not because that's the job they want or that's what they want to be. I think it's like that stepping stone to get somewhere else. But in the hospital I don't think that there is that - like they're going to help you move up or get a different training- so then I don't think so. No. That cross training which is helpful, and it's good. But yeah . . . It's not. I think that we do so much but the pay does not show (Sofia, personal interview, June 13, 2013).

While it would seem obvious that the next step upwards for CNAs is to train as an RN, there are many technical occupations in hospitals, particularly compared to other settings, like nursing homes. CNAs get the opportunity to mix with these kinds of workers, and even though many originally aspired to be nurses, some of them found other occupations more appealing. Most of those who were pursuing, or thinking about, further training did choose either nursing or one of the technician jobs within healthcare, although some still had longer-term professional ambitions.

Nursing. After working at another hospital for 6 years, Marta took a year off with her new baby and to recover from two surgeries. During this time she also completed her

prerequisites for her nursing course. However, she found she did not like staying at home, and applied to Northside because it was near to her house. She combines full-time work with her nursing studies:

I'm at [For-Profit Career School] now. I graduate next year in April. It's a two-year [course]. . . . Because I do go to school I mainly only work Saturday, Sunday, Monday, Tuesday. And my managers are very good with this. My manager goes to school, too, so she knows what it is. And everybody else has weekends off. So I work every weekend. It's beneficial to them. "Oh, you want to work every weekend. Oh, great. I don't have to work weekends" (Marta, personal interview, May 23, 2013).

But she has ambitions to go even further and her eventual goal is to be a Nurse

Anesthetist:

And then I'll have to get my Master's in going to Anesthesiology School. After the two surgeries [I've had], I like surgery now. I give myself ten years, because once you graduate and be a nurse then you have to get your Master's, and then you have to be an ICU nurse for three years minimum before you can apply to Anesthesiology School. That's the plan, quote, unquote (Marta, personal interview, May 23, 2013).

Leah currently works PRN (as needed) at Northside, and at another senior housing project with a nursing home unit. After 7 years working as a CNA while taking her prerequisites, Leah was about to start in a nursing program, although she is unable to get tuition reimbursement because she is a part-time worker:

I've been [taking] one class at a time, you know, for nursing. I go to [Local Community College]. Yeah, so I've been doing a class there, still I'm taking two classes now, and then I have to be in the nursing program in the fall, cause I'm done with my prerequisites now, it's been like five years of it. So, I'm just excited, you know. I don't think I could've done it without my experience. . . . I mean, definitely, I know God has me as a CNA for many reasons. Like, definitely, I always give the best care, but I'm ready to be a nurse [laughs]. Just relax from so much patient care (Leah, personal interview, February 11, 2013).

Elena went back to college after dropping out from her nursing course due to pregnancy:

I was at [Local Public University] and then I had – it was just too much, myself, to pay for. So I actually left. I'm at . . . [Local] community college, just finishing up there, because they have a nursing program. Now, financially, I get reimbursed and financial aid helps me a lot so I don't pay nothing. [Laughs]. So, that was a big thing for me. That was what happened, but then I stopped for a little bit due to myself personally, I went through a divorce, and just emotional, so I stopped. And looking for a new home, and all that stuff. Now I'm back in school! [Laughs]. I got life together, back in school. [Laughs]. (Elena, personal interview, December 3, 2012).

Although Elena is divorced from her husband, they have a good parenting relationship.

Elena is caring for her mother, who has cancer, as well as studying to be a nurse, so the children live mainly with their father: "And then when he's at work I watch them. So, it works out. Mainly I'll go out to the house and watch the kids where they're staying"

(Elena, personal interview, December 3, 2012). It was not always easy when they split up, and for a while Elena stopped her classes. "It was a lot, you know, like I said, that's really why I had left school and everything, it was just a lot to deal with. But now things are coming back together and I'm focused" (Elena, personal interview, December 3, 2012).

At 23, Laura has worked as a CNA for over 4 years, in nursing homes and in home care before starting at Northside. She loves the work, but not the money:

I mean if it was for me, if they were to like give me like a \$2 raise or a \$3 raise or maybe just to \$2, I'll be happy with my job. I like what I do, but I know I'm capable of doing more, so might as well go to school and see where I stop at (Laura, personal interview, June 11, 2013).

She has now started her nursing prerequisites:

I'm actually going into nursing. I'm taking my pre-reqs . . . and if everything is okay . . . I'm planning on getting my bachelor's by 27 so. That's my goal right now. That's the main one, to just go to school full-time and, I mean, of course work here and stuff. . . . I'm taking a summer class, just one summer class. But then when fall comes in, I'm going to become a full-time student. I know it's going to be hard full-time and then full-time here. But I think I can manage it. If I can pull up extra shifts and overtime at work, I know I can do it at school too. So.

I'm hoping to start [at Local Teaching Hospital] at the end of the year of December 2014 (Laura, personal interview, June 11, 2013).

Like Laura, Anne is in college training to be an RN, but her ultimate ambition is to be a doctor. At 19 she is barely older than most undergraduate freshmen, but already has almost 4 years of work experience in healthcare settings:

I'm actually planning to do medicine. And right now I started off as a nurse because I want to do my four year undergrad as a nurse, nursing degree then go for a graduate. But since I'm moving out of state I had to change my plan and go do my major in Biology and then do Medicine. But that's what I want to do. Be a doctor (Anne, personal interview, June 18, 2013).

Graciela, who had dropped out of her nursing course at university, eventually returned to studying, taking the cheaper associate degree route at local community colleges:

So it was all student loans, but 2006 I started at [Local Community College] with the pre-requisites for Nursing. So I went, I finished all my pre-requisites [there] for [Private Nursing College] and for [Another Community College] and I applied for [Another Community College] because they were cheaper. I finished in May. I just took my class and so I passed the nursing board Tuesday (Graciela, personal interview, July 18, 2013).

Graciela was just waiting to receive her RN license when I interviewed her, and hoped to apply for a job as an RN at Northside. She may have deferred her dreams of nursing for a while, but she was finally a registered nurse 20 years after her initial entry into nursing school. She told me that she planned to carry on and complete her BSN, as that was preferred by Magnet nursing programs like Northside.

While some CNAs go into nursing, that is not their only option. Other CNAs choose one of the more specialized technical occupations that they are exposed to in the hospital.

Other healthcare occupations. Although George had originally planned to go into

nursing, he changed his mind and is planning to train as a respiratory therapist:

I just made friends with a few therapists and they told me the stuff—the basic things I need to know. Which is pretty cool, I even observed a few of them. They actually took me to the room and showed me exactly what they had to do, so I was like, “This is easy. This is definitely something I could do” (George, personal interview, June 4, 2013).

He had been taking pre-requisites for the RN course, and has found that most will transfer for his respiratory therapy course:

I was finishing up all of my pre-reqs before I got into the RN program and I actually needed one or two more classes left and then I just decided you know what? Forget it! And I was so close to it but then I just realized maybe there’s something else better. And sure enough- Respiratory [Therapy] and I think they’re accepting majority of the classes I took already so that’s okay, it’s an easy switch over I’d say. I would do that part-time - . . . I actually like to do other things besides the healthcare thing (George, personal interview, June 4, 2013).

Charles, who left university without graduating, enjoys working with patients but said he doesn’t find the work challenging. He still has ambitions to be a physician, but his immediate goals are less lofty, and he, too, has been taking additional training at community colleges:

I have taken a number of other certification classes including the EMT training, phlebotomy and EKG. . . . Part of the reason moving [here] was for those training classes, those have been through the city [community] colleges . . . and I’m starting into a full-time for a paramedic. . . . After I finish the associate’s degree I’m going to go back and finish my bachelors and hopefully graduate school after that (Charles, personal interview, June 18, 2013).

Meanwhile, he was about to change jobs at Northside after 8 months working there as a CNA:

I’m moving to the laboratory to be a phlebotomist. . . . I start in early July. I have applied for variety of other jobs, approached with my resume and there’s been some interest and some not, finally I was able to do this (Charles, personal interview, June 18, 2013).

Maria, who originally trained as a Medical Assistant before she became a CNA, is

planning to go further, although her family finances make it difficult. She may be only

35, but she has a lot on her shoulders:

Now I'm in the position where I feel very comfortable which, I don't wanna feel comfortable. . . . I love what I do, I love my job, but I know I could do a little bit more. So, I'm going for nursing, and I feel that being a nurse, and being a nurse's aide, I know I know I'll be able to help them more. My plan for now, it's,– I'm helping out my husband a lot pay the bills and stuff, and I still have three girls, . . . um, my hands are pretty full. And I know that if I signed myself up for school right now, I'm not going to be able to focus on school. There is no way. So, it's very difficult but, um, but I actually told my husband, I gave him an ultimatum. Either I go to school full-time and quit my job, or he's gonna have to find another way to see, because I'm determined to go, to start back in May. . . . I can't go for nursing, because, first, I won't be able to manage it because of my girls. But if I take a shorter course to become a paramedic, and I know it's gonna be more intense and it's not as, as a lot of requirements as a nurse. You need to take bio and everything. Then, from there, if I go to become an EMT, get a little bit more money, move myself as an EMT, then maybe when my income gets a little bit more I'll be able to move along. And my girls are a bit older. And I already got the point where I already paid my course. I just have to see when I'm gonna start it. I've been putting on hold, but it's there, the money's there already, so. (Maria, personal interview, February 11, 2013).

Maria is an extreme example of incremental training, seeing the EMT training as one step towards the final goal of becoming an RN. She had her children very young, and her youngest is now nine years old. She is not sure whether the latest reunion with her husband will be successful, and is prepared to go it alone if it is not. Like others, there is a sense of now-or-never about her attitude to further training.

Teddy, who is 56 and works in the Wound Care unit, feels that it is too late for him to train as a nurse, but he has ambitions to complete more training in wound care:

I prefer to go into the Wound Care because getting to an age that I think I'm aging and I don't want to go into this and that. I said, "Why am I going to finish another four year course and do that?" But I can do better things to earn me some good money. I decided to go into the Wound Care because within three years of onsite I can just take the test and get my Wound Care certification and I can decide to go on Home Health. . . . I mean, it is my third year. I'm getting ready [to] have a review classes and take my tests and become a Wound Care Associate (Teddy,

personal interview, May 18, 2013).

Angela, his colleague in the Wound Care unit also has plans in hand for further training. She had already taken the basic manufacturers' certification to work with patients using the hyperbaric oxygen chambers (HBOs). Patients, often diabetic, spend up to two hours per day for three to four weeks in these chambers to hasten wound healing, and must be supervised in case of any difficulties or discomfort. The Unit Manager told me that it was usually an LPN or above who would have this role (field notes, 11/27/12). However, Angela had worked as an LPN in her home country, but was unable to transfer her qualification when she emigrated. She was preparing to take some advanced training to become an HBO therapist. The equipment manufacturers offer a training course in Florida:

I need to take the class. Not here, I think it's in Florida. . . . I think it's not for a long time, it's only two week. It's hard, . . . but I start. . . studying, I have the book. I think I has to work more hours in HBO. I think it's supposed to be 500 hours. I had only 300-something. When I finish I have to pass my test. This is my goal for this year. Now in HBO, [the therapist], she explain me everything every day, something about the machines, something about everything. I had the book in my house, I studied the book. I think when I'm finished my 500 hours I'm going to pass my test (Angela, personal interview, June 25, 2013).

This example of cross-training was unusual in the hospital, since it was external-provided by the manufacturer of the equipment- so was accredited and transferrable, unlike the Scrub Tech training that Sofia had received. However, the experience of working in the maternity OR had given Sofia a taste for that kind of work, and she is considering going back to school so she can earn a better salary:

But I mean I also know my budget and I feel at this point that's why I'm deciding to go back to school because at this point I feel like I'm always on a budget and that's not how I want to live. So that's why I'm thinking, if I go back to school then I'm going to be able to increase that income doing something that I do like and working the same schedule, but three days, with a better income (Sofia,

personal interview, June 13, 2013).

At 32, she is also thinking about how she would manage if she had a family:

I like the healthcare field. I like working in a hospital. I like the hours, the scheduling is flexible. If however I was to start a family, I wouldn't mind working three days a week and being off the rest of the week. So I think that there's some flexibility when it comes to that. I think at that point, I wouldn't want to have a nine to five, Monday through Friday, although the downside is that sometimes we have to work weekends -but it's not every weekend (Sofia, personal interview, June 13, 2013).

Although she has not taken any concrete steps yet, she is thinking about training as a Surgical Technician, building on her experience:

And . . . that is something that I'm taking into consideration to go back to school for surgery, to be as a surgical technician. I wanted to continue for a bachelor's but I didn't yet. So now I'm thinking I want to do like surgery. Something with surgery. I really like the feeling when I'm in the OR. So I think that that's my calling. I would need to go back to school and then I don't know. All I know is that once you go to school for that, they show you how to [use a] whole bunch of other instruments, and then you can work in any other surgery case and not specific to just [Maternity] - which is the training that I have now (Sofia, personal interview, June 13, 2013).

One of the unintended consequences of interviewing people about their work is that it can validate their experience, and make the interviewees think differently about their lives.

As Sofia said:

If I may say something -I think that by me telling you everything that I could do it's just making me realize like I really do need to go back to school. I know a lot and I am not utilizing everything to my advantage . . . so this is good. I get to see everything that I do. I'm like, wow! I do a lot (Sofia, personal interview, June 13, 2013).

Melanie, who completed the LPN training but did not take the exam, is considering her future options. Like George, working in the hospital has made her reconsider becoming a nurse and she is evaluating other options within the healthcare field:

If I hadn't gone for LPN, I would be in school right now. I'm kind of stuck right now. I'm a little disappointed in myself, it's been five years so it's definitely past time that I can't even get any of those credits back, I have to start all over. And being in the hospital and seeing it instead of just studying it, it's completely different. Seeing what the nurses, all the responsibility they have and how stressed they are, not having any time for themselves. Right now I don't feel like that's the direction I want to go in. I love the job, I do, I absolutely love being a CNA. If they paid more, I'd probably do it for the rest of my life. But I'm looking into other things right now, just probably not the RN part. Maybe like therapy or dialysis or something that like specializes in some other area. Or maybe hospice, I think I'd like hospice. But not, let's say, nursing. It's very difficult and I know it's very time consuming and very stressful, and I like to have some time with myself and enjoy with my family. I'm seeing my mom so stressed with all of it. Right now, it's a no. Maybe another, and definitely in healthcare, but maybe not in the direction of an RN (Melanie, personal interview, May 30, 2013).

As mentioned earlier, two of the interviewees were enrolled in bachelor's courses, but not for nursing. However, they were still working as CNAs, even while carrying a full-time course load. The pattern of balancing full-time study and part-time work, or vice versa, is a common thread among CNAs who are studying.

Bachelor's degrees. Ruth became a CNA to get a feel for healthcare work, but her ambition was to be a doctor. For a while she was combining full-time work with part-time study but she is another interviewee who had a now-or-never moment. She is currently a psychology major:

I started going to school part-time, working full-time, and then – I had to come to a decision where it was, do I either forget about going to that path or do I just stay working? I had talked with my husband, and said, "I really think this is what I wanna do, this is my last hurrah. If I had one last thing that I wanna complete, like, as in education-wise, I think I wanna try for this one." So he said, "Okay, go ahead." So, I quit there working after five years and then I just started working part-time, different jobs, and I started going to school. That was a huge paradigm change to go from working full-time to part-time. And then being a full-time student. It was very, very weird (Ruth, personal interview, November 30, 2012).

Alex is a student in a four year college, but not for nursing. She actually finds that the hospital work helps her in understanding her math in a more concrete way:

Depending on the patients' humor, they're like, "So, are you in school for nursing?" Hell no! I actually finally found something I was good at. I'm going for a math major and hopefully, a physics major as well. There's a lot of meteorology that I wanna do as well as quantum physics and theoretical physics that I wanna get into. You know, and just having that math degree, I've just found so much fun with it and it really gives the extra boost to the day at work. But I've noticed one thing that has helped me is actually working. . . . So I found my talent, and . . . doing the actual work and seeing the applications of things in life led me to understanding actual collegiate work for any kind of like math or comprehension. So, in a way, I'm really grateful for the, quote, "educations" I'm getting, because there's stupid little quirky things I do, like, somebody ate a pie, so I did the volume of the pie [laughs] (Alex, personal interview, January 15, 2013).

Her family have been very supportive, although finances are still tight:

It was actually my fiancé that told me, you know, you gotta go back to school. He actually, literally, held my hand when going into [Community] College and signing up for those classes. He's like, you know, you gotta do it. And then, one Christmas present, my mom, my brother and him all pooled in money for a laptop. It was just the sweetest thing. So I've gotten the most, but most, encouragement from my family and it's like, when we come here, it's just like, any problems that we've had in the past with money she was, "Oh we're family, . . . this is a safe place to be, the supportive environment that we need" (Alex, personal interview, January 15, 2013).

She is currently studying part-time, but, like Ruth, there is a sense of "now or never"

about her pursuit of higher education, and she plans to go full-time, but continue part-time working.

It's part-time, it's nine credit hours per semester. But I will be going full-time, because now I'm not getting any younger here! . . . I'm not thinking of dropping the hours, but I might have to, at work. Because I still do need to get paid, I need to buy books, but I was thinking I would get more [Federal Student Aid]. But I just don't like asking for money, either from my fiancé or my mom. Even though we're gonna get married, it's just like, "I still don't wanna ask you for money!" He's just like, "It's our money" (Alex, personal interview, January 15, 2013).

While many college students today graduate burdened with debt, or rely on parental financial support, the CNAs I interviewed were prepared to look for the cheaper options for higher education, such as taking prerequisites or associate degrees at community colleges, pursuing part-time study while working full-time, or full-time study

combined with part-time work. This can be seen as a “cafeteria” approach to education, choosing classes at a range of different institutions on the basis of cost or convenience. While it takes some of them many years to reach their goals, some of them are willing to go that distance, and some, for example Graciela, achieve their goals.

Conclusions

In answer to my initial question as to whether the CNA position was a terminal career or a stop on the way to other options, the answer is that it can be either. Most CNAs came from families where money was tight and they had to work to support themselves and contribute to the family income. Even those who had decided on a nursing or medical career at high school did not expect to study full-time and complete their education in a couple of years. Most fit the criteria of a non-traditional student, being over 24, working class and from an ethnic minority. Working as a CNA, particularly in a hospital, gave them relevant experience and a wage while they worked on their education. In some cases, they were also able to receive tuition reimbursement from the hospital, and encouragement from their Unit Managers. The scheduling at Northside gave them the flexibility they needed to combine work and study.

While I originally thought I might find a pattern of people who had retrained in healthcare after a period on welfare (Centers for Disease Control 2008; Lewis et al. 2005; Squillace et al. 2007), this was not the case, at least at Northside. Most interviewees had a prodigious work ethic and more than a minimum education level, and many had worked in occupations that would be considered higher status than that of a CNA. Most of those who married young also worked while having children, although some took time off work to raise their families, and became CNAs after that. While some of this older group

felt that they would have liked to train as a nurse, there was the common feeling that they were too old, and could not afford the time or money that was involved, when they could be putting that effort into supporting their children's education.

Those who were continuing their education chose, for the most part, vocational courses that led to an occupational credential as well as, or instead of, an academic one, for example, an RN credential as well as an associate's degree. Their educational pursuits were practical and designed to lead to a level of upward mobility, something that remaining as a CNA would not achieve. Some of these current students also had ambitions beyond their current educational course, although it is not clear whether these were lofty dreams, or game plans.

One significant factor may be that the majority of those I interviewed were first or second generation immigrants, mostly Latinas. First generation immigrants, particularly those from Latin America, suffer a considerable earnings disadvantage compared to native-born workers, one that persists during their working lives (Borjas 2006). The second generation immigrants show some earnings improvement compared to their parents, but most of this is due to differences in educational attainment. Furthermore, this pattern of intergenerational improvement is also declining. The probability of upward mobility is reduced for those second-generation immigrants who grow up in ethnic enclaves and greatest for those whose assimilation and acculturation is fastest (Borjas 2006). However it is notable that those whose heritage meant they were fluent in Spanish found that the hospital valued that by using them as informal interpreters, even if it was not rewarded financially.

Clearly, the study participants understood that education was key for upward

mobility, and had realistic plans to achieve their short-term and mid-term goals. The lack of a widely-accepted, accredited, career ladder within the CNA track means that CNAs who wish to progress must make a greater investment of time and money to pursue outside training and education. The accredited second-tier certification for CNAs working in acute hospitals in Oregon, and the Certified Patient Care Technician accreditation are examples of what a career ladder might look like, but it is not clear that the extra investment is worthwhile when those certifications are not widely required by hospitals, and the financial benefits are not great. CNAs may find that going for a more widely-accepted nursing or technical qualification has a greater payoff in terms of pay and career advancement, particularly if they wish to continue working in a hospital environment. However, since hospitals are already providing cross-training for their CNAs, it would benefit the CNAs if that cross-training came with accreditation, and could be transferable to other jobs, or even accepted by educational institutions. This would help to speed up the slow progress of those combining work and study.

As I have stated before, studies of CNAs have been previously limited to those in nursing homes or, to a lesser extent, in home care settings. Hospitals provide a very different kind of environment compared to the much flatter hierarchy found in nursing homes. While this places CNAs at the bottom in terms of status, barely above the housekeeping staff, it does offer some very real benefits, and not just higher pay, health insurance and tuition benefits. CNAs in an acute care setting gain a great deal of practical, and even medical, knowledge, even if this is experiential rather than accredited. They also get an opportunity to work alongside a whole range of occupations, including professional nurses and doctors, and a variety of therapists and technical workers. They

are able to observe the kinds of jobs they might consider aiming for, and even learn from those doing the jobs, as George and Angela did. It seems that this environment, and even the cross-training, provides some CNAs with the confidence that they could do more, like Sofia and Maria. In addition, there is often encouragement from their Unit Managers, and in a hospital like Northside that values education (as demonstrated in their Magnet nursing status) there is a rich environment for those who would like to improve their education, even if it is a slow process.

This dynamic, incremental path to further education deserves more study, and it may be that there are other occupations that have this pattern. We already know that almost half hospital CNAs nationally have some college education (Yamada 2004) and it would be useful to look at this picture more closely to understand what kind of education, and to what extent this is a picture of education that is ongoing or that was terminated before completion of a course. In the case of the Northside Hospital CNAs, the CNA certification sometimes acted as the “booby prize” for dropped education, or as a prerequisite for a nursing course, or as a terminal certification for some who considered themselves too old, or with too many responsibilities at home. Even studies focusing on non-traditional students tend to assume that these students gain their education within a relatively short time at a single institution, even if they are combining work and study. In fact, leaving an institution without graduating is seen as problematic (at least for the institution). While some traditional students may take additional classes at cheaper institutions in order to complete their degrees more cheaply and quickly, many of my interviewees were taking a “cafeteria” approach to education and training; taking classes at different institutions at various times to make up their own path to graduation.

In his book, “Respect in a World of Inequality” (2003: 32-37) Richard Sennett recounts a community group meeting he attended in 1971 at Cabrini Green, the public housing project in Chicago where he lived as a child. The meeting was intended to provide role models for the residents, by inviting successful alumni of the project to inspire current residents. Alongside Dr. Sennett, the role models included a Puerto Rican eye surgeon and other more modest successes; a secretary to a union official and a black man who had managed to become union electrician, one of the most racist trades in Chicago. The surgeon gave an inspiring motivational speech along the lines of “If I could do it, so could you,” but the audience were angry and heckling. His self-confidence made them feel inferior and disrespected, and his speech was long on inspirational platitudes, but short on concrete steps that could help them follow in his footsteps. The secretary had a much more positive reception: She had given them those steps, and her outcome seemed much more manageable to people whose (generally realistic) aspirations were more limited. While a few of my participants had long-term aspirations for a career in medicine, for the most part they were taking incremental steps to a career in nursing or as a health care technician. But they must, for the most part, take those steps on their own, and create their own dynamic opportunity ladder.

In the concluding chapter, I sum up the major findings of this study, look at the limitations, and suggest some avenues for further research. Since this research looked at a small sample in an area that has not been previously studied, it should not be seen as more than a pilot study. There are many areas that could benefit from additional research, both to increase the sample size, and to answer some of the questions that are raised by this study.

CHAPTER SIX

CONCLUSIONS

Nursing assistants who work in hospitals are an overlooked occupation. They are in many cases the staff seen most frequently by patients. They act as the gatekeepers to RNs, since they are usually the people who answer patient call lights first. They are the eyes and ears of the hospital at the unit level, since in their routine tasks of personal care and routine vital signs measurement they are in a position to notice if patients are in physical or emotional difficulties. Yet, they are mentioned only as an afterthought in healthcare or nursing literatures, or are seen as problematic: not real nurses, and therefore unable to provide thorough and professional patient care.

There is extensive literature on nursing assistants who work in nursing homes, since they are the largest occupational group there, and there are concerns about both staff retention and staff quality. However, the work of nursing-home-based CNAs is very different from those in acute-care hospitals; patients' primary reason for being in hospital is their need for medical care, and personal care given by CNAs takes place within that context and is subservient to medical treatment (Strauss 1977). In addition, they undertake their work under the supervision of RNs, who have responsibility for the work of CNAs. While RNs are the largest occupational group within hospitals, CNAs are a large and expanding group, and their work is poorly-understood. This study is the first examination of the work and role of CNAs who work in hospitals.

My research study was a qualitative, interview-based study of nursing assistants in a large acute care hospital in a major Midwestern metropolis. The semi-structured interviews focused on the tasks performed by nursing assistants, their attitudes to care, their education and previous occupations and their future work plans. I also collected demographic information about family, ethnicity and housing. The study used a methodology of modified grounded theory to identify common themes and to test emerging themes from earlier interviews in later ones (Charmaz 2006; Strauss and Corbin 1990). This led to a revision of the schedule of questions following the first 7 interviews, to exclude questions that were not relevant and to introduce new questions to explore emerging themes (see Appendices E and F).

Research Questions

Given the lack of previous literature that deals directly with hospital CNAs, the research questions developed for this dissertation arose mainly from my own experience as a hospital patient in 2005, and from the indirect literature on nursing, and the extensive literature on care work. Since I used a grounded theory methodology, these were investigative questions rather than hypotheses that could be tested. Further questions emerged during the interviewing stage, as a result of the methodology. There were three main research questions that emerged from my observations as a patient, from the literature review and from the interviewing stage:

First, where do CNAs fit into the labor process of hospital nursing, including the work of both registered nurses and licensed practical nurses? What factors have influenced the changing labor process?

Second, how do CNAs understand their work of personal care? Are CNAs

required to perform emotional labor? Do they see their work as instrumental or affective, or both?

Lastly, do CNAs have career aspirations beyond that of being a CNA? Are these aspirations realistically achievable? Is nursing assisting a terminal career or a stepping stone to other careers? Does their location within hospitals help or hinder career advancement for hospital CNAs?

Summary of Main Findings

Since this study was limited in scope, and the first to study this occupational group, the answers to the research questions can only be tentative and the starting point for further research. However, I had rich data on all the questions, even accepting the limitations of the study.

In examining the labor process and division of labor at the unit level, I found that CNAs are now responsible for the majority of bedside care, although under the supervision of RNs. The extent to which RNs perform personal care depends on the unit specialism, the level of care required by patients and by the number of patients each RN is responsible for. While CNAs in inpatient units typically care for around nine named patients, regardless of unit, RNs usually have three patients in higher-care units, such as the IMCU, and up to five patients in lower-care units. In high care units, RNs are more likely to share some of the bedside care, including bathing, since patients are less able to contribute to their own care. CNAs have routines and scheduled tasks, such as rounds of vital signs and preparations for mealtimes and bedtimes, meaning that they perform much of their work without direct instructions from RNs. This includes making their own schedules for tasks like bathing of patients.

LPNs have largely been removed from hospital nursing and into other settings, such as nursing homes and out-patient services (Brannon 1990; 1994; Seago et al. 2004). Northside Hospital is an extreme example of this, with only 6 LPNs in the whole hospital. This means that the division of labor between RNs and auxiliaries is much clearer since, unlike LPNs, CNAs are unable to substitute for RNs. While CNAs have been cross-trained to enhance their flexibility in the workplace, this does not impinge on the labor process of RNs, since the additional tasks performed by CNAs do not overlap with those of RNs. Instead, cross-training enables the replacement of clerical and technical workers by CNAs in particular contexts, while the cross-trained CNAs continue to perform their regular tasks, or at least, to fill in when required. For example, while CNAs trained as Unit Assistants will be scheduled for some shifts as pure CNAs and other shifts as Unit Assistants, even when they are responsible for the clerical work of the unit they can step in to answer call-lights and assist CNA colleagues at busy times.

In terms of CNA's attitudes to care, there are similarities to research findings from nursing homes and other residential settings. While the "professional" approach to healthcare provision demands a detached, depersonalizing view of patients (Chambliss 1996; Strauss 1997), CNAs turn this on its head by rejecting the idea of depersonalization and prioritizing what they define as 'real' care, which they see as providing individualized and personalized care to each patient, care which is both instrumental and affective (Bullock and Waugh 2004; Diamond 1992). This was frequently expressed as the kind of care that they would want for their own family members, and there was resistance to the practice of treating certain patients as VIPs, for example, those who were indeed family members of hospital staff. CNAs said that all patients should receive the

best care, appropriate to their needs, which included medical, emotional and social needs.

However, while the family metaphor may be common to CNAs in nursing homes and in hospitals, there are differences between the two in terms of the institutional basis for care. In residential and nursing homes affective care is commodified, since having staff who care about, as well as caring for, residents is a selling point for those institutions, where residents (or their families) are customers rather than patients (Berdes and Eckert 2007; Tronto 1993). Patients in hospitals are there because of acute medical issues, and their medical treatment takes priority over personal treatment, their identity as a patient over that of a customer, and instrumental over affective care (Strauss 1997). Nonetheless, affective care is important to patients, as the old adage, “doctors cure, nurses care,” attests. Patient satisfaction surveys are an important part of modern hospitals, and the fact that several CNAs mentioned that patients had nominated them as model employees, or written letters or cards to the hospital mentioning CNAs by name, shows the importance of personal care to patients. In a situation where patients are often fearful, and are subject to a number of different professionals and technicians examining, prodding, discussing and subjecting them to various medical treatments, the relationship with the CNA can provide a humanizing face to the hospital; a regular friendly, approachable person, providing conversation and gentle personal care and touch that is the opposite of the medical approach. While the taking of vital signs and the personal hygiene tasks and dirty work have a medical rationale, they also provide an opportunity to get to know patients and make them feel more comfortable and relaxed in a difficult and uncomfortable situation.

I am reminded of an experience I had while I was in the hospital. When I was

returned to my room after major abdominal surgery, I discovered that I had a wound to my head, and my hair was matted with dried blood. I never discovered how I had injured my head, and none of the professional staff appeared interested in it, since it was not serious and had nothing to do with my treatment or diagnosis. Nonetheless, it was uncomfortable for me, and I was unable to shower due to my surgical wound. I mentioned this to my CNA, and she returned later with a dry shampoo cap, which she used to gently clean my hair. Almost a decade after the event, this is one of the things that I remember most clearly about my own experience, and I remember that CNA more clearly than the doctors and nurses that treated me for cancer.

It has been noted that in residential care settings nursing aides use boundary work (Thorne 1993) to create categories of patients who are seen as co-operative and worthy of affective and instrumental care, the “lovelies” and those that are perceived as difficult and deserving only of instrumental care, the “disliked” (Berdes and Eckert 2007; Lee-Treweek 1996). However, violent behavior from patients tends to be rationalized and minimized (Åkerström 2000). In the hospital setting, many CNAs also excuse violent patients by framing it in various ways as not real violence (Goffman [1974] 1986) because their behavior is usually seen as resulting from their medical conditions or mental disorders. But in hospitals, the strategies that CNAs use in dealing with difficult patients or unpleasant behavior tend to be personal to the CNA, rather than based on agreed and widely-shared patient categories. Most of the participants used a strategy that I have called “killing them with kindness,” which means ramping up the affective care by being particularly nice and kind and hoping to win difficult patients around in that way. Some CNAs used an opposite strategy, which I have called “being professional,” which

meant offering only instrumental care, and having minimum contact with the patient, with no “extras.” This second strategy was seen by all the CNAs as an inferior form of care, although it met the formal hospital requirements. Interestingly, this strategy was more likely to be used by male CNAs, although the small sample size means that this conclusion can only be provisional.

CNAs perform mostly personal care tasks, rather than medical procedures. They also work under the supervision of RNs, who have legal responsibility for patient care. Nevertheless, they consider themselves responsible for patients. Their sense of responsibility for the wider well-being of patients can be seen as reflective of what Foucault called pastoral power, a holistic idea of care that encompasses all the individual needs of members of the “flock” (Foucault 1988; Lee-Treweek 1996). It may be that in the absence of therapeutic responsibility, CNAs seek to carve out a niche for their work within the hospital that focuses on the wider well-being of patients, including physical and emotional comfort, and even practical provision of items that they believe patients need, such as clean clothes for a homeless man, or baby items for poor mothers.

While it appears that hospital managers do not require the performance of affective labor or emotional labor, it is clearly an important part of the interactions between CNAs and patients, as it is in other interactional service work (Hochschild 1983). While a poor bedside manner may be acceptable in a doctor, it would probably not be in a CNA. Certainly, CNAs themselves talk disparagingly about colleagues who are cold or brusque with patients. But this aspect of the work is not included in the training of CNAs, and my interviewees did not mention that it as one of the aspects prioritized by their immediate managers or by the hospital administration.

The final research questions concern the career paths of CNAs, and their career aspirations. I found that most hospital CNAs did not start out with the ambition of being a CNA. CNA training allows people to start in a healthcare career with a low investment of time and money, generally only a few weeks and less than \$1000. In addition, some nursing courses now require CNA certification as a prerequisite, or include it as an early part of the nursing training. In fact, a number of my interviewees had started out in nursing courses, but had left before graduating for various reasons, often due to family responsibilities. Sometimes the CNA certification had already been obtained, and in other cases they chose to undertake CNA training as a way to stay in a nursing-related occupation while considering their options. In yet further cases, participants had become CNAs as a way of gaining experience in the hospital environment before entering a nursing or other healthcare training course, since nursing courses and medical schools strongly prefer applicants with some hands-on healthcare experience (The Princeton Review 2014). These pathways all indicate that many CNAs see the occupation as a starting point, rather than an end point. However, there was an older cohort, those in their mid-40s or above, who had other careers or raised a family before retraining as a CNA. They tended to focus on their children's educational opportunities over their own, and felt that their time had passed. These were the least likely to be considering further training and career progression, which is unsurprising given the required investment of time and money.

For many CNAs, the occupation was a stepping stone to other careers, mainly in healthcare. While the educational requirements for CNAs are very low (Illinois Department of Public Health N.d.a), those who work in hospitals have more education on

average (Yamada 2002). The vast majority (81%) of CNAs who participated in this study had at least some college education. Many were combining full-time work with higher education, which was achieved incrementally, over many years. While there is little in the way of a formal career ladder for CNAs, one key finding of this research is that many CNAs are working on creating their own pathways in a flexible and dynamic way. This offers an interesting perspective on low-waged, but stable, work and the possibilities for social mobility.

The location of CNAs in a hospital setting, as compared with other healthcare settings, supports career progression in a number of ways. First, the highly hierarchical and specialized occupational structure of hospitals does provide a vision of a career ladder, compared with the relatively flat structure of nursing home staffing and the isolation of home health care. Contact with, and observation of, the variety of technical occupations in hospitals can give CNAs new ideas of the possibilities that might be open to them. Some CNAs started off with aspirations to become graduate nurses, but familiarity with other technical healthcare occupations changed their aspirations, particularly as RN training requires a great investment in time and money if acquired part-time over many years.

Another factor that may affect career development is that the experiential learning opportunities in hospitals are greater than those in nursing homes, both because of the acute medical environment, and because of the range of professionals (particularly RNs) who can provide information and sometimes informal teaching to CNAs. In some cases, cross-training provides CNAs with new skills and experience that they can use to explore further training and accreditation. However, the lack of accreditation for cross-training

means that it is not transferrable to new jobs, or accepted as prior credit if the CNAs undertake further education.

Finally, there are institutional supports, both indirect and direct, for career development. The 24/7 staffing requirements of hospitals means that there is flexibility in shift patterns which can help CNAs combine college and work, in various ways and proportions. Many CNAs also mentioned that Unit Managers encouraged and supported them in their education, particularly if they were in nursing courses. In addition, hospitals are more likely than nursing homes or home health agencies to offer employee benefits (Yamada 2002). Northside Hospital provides both health insurance and tuition support to full-time employees, and these can help to offset the costs of education to CNAs.

The CNAs I interviewed who were in college were all combining work and education, meaning that their further qualifications sometimes took many years to achieve. Some had breaks in their studies due to family situations, such as divorce, personal or family illnesses or childcare. Most of them seemed to have realistic expectations concerning their career trajectories, even if some had longer-term plans that might be more difficult to achieve. In this era, when students frequently leave college with mountainous debt and no guarantee of sustainable employment, it may be that the idea of using the CNA certification as a springboard to a pattern of work and study that will eventually lead to a secure career is a sensible one, particularly since healthcare occupations are areas of employment growth. However, this pattern of incremental, dynamic, stop-start education towards career progression has not been studied.

Contributions to the Literature

The findings contribute to the sociological and nursing literatures in a number of

ways. First, in terms of the labor process and the division of labor, this study builds on previous work that focused on the nursing labor process, particularly that of Brannon (1990; 1994a; 1994b; 1996). The findings on cross-training contribute to the growing literature on lean service in healthcare (Nelson-Peterson and Leppa 2007; Spears 2005; Viswanathan and Salmon 2000), although the Kaizen/Continuous Quality Improvement system seems to be more popular in the literature and in health management circles than as actual practice in hospitals.

In particular, the modern iteration of team nursing differs from the earlier post-war version in a number of ways. In that era, auxiliaries, including LPNs and CNAs, were more numerous in many hospitals than RNs (Brannon 1990; 1994a; 1994b; Sacks 1988). This led to dissatisfaction by RNs who were responsible for care they did not give, and who lost authority and pay leverage because of the possibility of substitution by LPNs (Brannon 1990; 1994; Reverby 1979). The new team nursing that was introduced in the 1990s retained the high proportion of RNs that was introduced under primary nursing, and largely removed LPNs from hospitals (Brannon 1994; 1996; Sacks 1988; Seago et al. 2004). However, CNAs have been retained to perform the routine bedside care. My findings concerning the work process of CNAs shows the bifurcation of the nursing process since LPNs are no longer present to substitute for RNs. This has two major implications. First, it increases the authority of RNs as managers of care and as supervisors of CNAs. Second, the cross-training of CNAs provides a more flexible workforce in the tradition of lean service, which improves efficiency while producing cost-savings that are important to hospital management (Brannon 1996). However, it does not impinge on the labor process of professional nurses, since the cross-training

allows CNAs to replace clerical and technical workers, not nurses. In this way, the priorities of both nurses and hospital managers are satisfied, while in the earlier version of team nursing, and under primary nursing, these two important stakeholders were often in conflict (Brannon 1990; 1994a; 1994b; 1996; Sacks 1988).

The findings also contribute to the literatures on care work and emotional labor. Hochschild's (1983) original work on emotional labor demonstrated that the capacity to be empathetic, or to withhold empathy, were often selected for in the recruitment of workers, and those characteristics were further developed through training or experience. Studies of care work have shown that people who enter these occupations are self-selecting and value the emotional side of care delivery (Wharton 1993). The experiencing of emotions on the job is not in itself emotional labor, since emotional labor is defined by the commodification of emotion work (Bullock and Waugh 2004; Lopez 2006; Theodosius 2006). Is selecting employees with a disposition towards caring the same as creating a situation in which emotional labor is required? I think it is, but there are still many areas of this debate that need further consideration, particularly in looking explicitly at the requirements of employers.

To further add to the complexity, the "professional" attitude to care is that professionals should maintain a certain detachment so as to be able to turn patients into "cases" and as a protection against burning out (Chambliss 1996; Strauss 1997). Some work on residential care suggests that care workers there are torn between their disposition towards affective care and the sense that it is unprofessional (Cancian 2000; Misra 2003, Stone 2000), while other studies emphasize the commodification of affective care, as residential homes are marketed as places where residents are treated like "family"

(Berdes and Eckert 2007).

My interviewees did not mention a sense of feeling a split between affective care and professionalism, and none spoke about being cautioned against caring for patients in an emotional sense. In fact, they all stated that good care included both instrumental and affective elements (Rakovski and Price-Glynn 2010; Stone 2000), and expressed that their ideal of the gold standard of care was the kind they would want for their own family. However, the kind of relationships that are built up over days or a few weeks at most are not the same as those of aides working in residential or home care situations over months or years. In fact, Leah spoke about the difficulties of working in home care, where clients wanted too much of their caregivers (Leah, personal interview, February 11, 2013). The affective care element in hospitals is more akin to kindness and empathy than a deeper, more personal relationship. While there may be moments of deeper intimacy in those relationships, as when CNAs comfort dying or distressed patients, these are fleeting.

While it is difficult to come to a definitive conclusion concerning emotional labor, it seems most likely that CNAs are selected (and are self-selecting) for a caring disposition, but that emotional labor is otherwise not an overt requirement for the job. It appears that affective care is expected in CNAs rather than discouraged as unprofessional (since CNAs are not seen as professionals). The effect of emotional labor/emotion work on CNAs needs further analysis- my findings suggest that negative effects arise mainly from difficult situations and difficult patients, rather than the routine and unproblematic delivery of care. However, some CNAs spoke about partitioning their lives, and not bringing their personal issues into work and vice versa, which may be an indication that

the emotional labor/emotion work required at work does have a detrimental effect on home life, as Hochschild (1989) suggests.

Implications of the Findings

These findings will be of interest to sociologists specializing in occupations, care work and healthcare, as well as nursing professionals and leaders, and healthcare planners.

My findings on the division of labor at the unit level have interesting implications for the understanding of the modern iteration of team nursing. The binary occupational structure due to the loss of LPNs in hospital units enhances the professional status of RNs, since they are not liable to substitution, and can gain status as supervisors and managers of care. But it also contributes to cost-cutting in hospitals, since cross-trained CNAs can substitute for full-time clerical and technical workers in particular units. For example, employing specialist accredited surgical technicians in the maternity department would be considerably more expensive than the present system of cross-trained Scrub Techs who are also CNAs.

Unlike previous nursing labor processes, including the earlier version of team nursing and the primary nursing that followed it, the current form of team nursing with the labor process split between CNAs and RNs seems to satisfy the two stakeholders that previously been in conflict. While RNs are still responsible for care they do not themselves deliver, a bone of contention in earlier team nursing, at least they are not liable to substitution in the skilled nursing tasks. This enhances pay and status and helps in the project of social closure (Dahle 2003). The removal of RNs from bedside nursing and their replacement by CNAs (who earn around one third of the pay of RNs) satisfies

the cost-cutting requirements of hospital managers. In addition, the breaking down of occupational boundaries through cross training produces further flexibility and cost-savings, since the dedicated clerical and technical staff who they replace are also more highly-paid than CNAs. While primary nursing was a short-lived phenomenon, the current labor process may be more stable, since it meets the needs of the major stakeholders; RNs, who are the largest occupational group in hospitals, and hospital management.

One issue of practice emerged concerning the labor process and division of labor between RNs and CNAs, at least at Northside Hospital. While the practice varies from unit to unit, CNAs in many units are not part of the general shift handover meetings, but simply take handover concerning their allotted patients from the outgoing CNA. This means that they do not always have a complete medical briefing on each patient. As they are often the first point of contact for patients, more complete briefing means that they would be better informed as to how to handle patients when they need to be moved, and what to look out for in terms of calling in the RNs as a matter of urgency, or of routine. At the moment, this often depends on individual knowledge levels of the CNAs as well as the information they have on individual patients. Including CNAs in the nursing handover meetings would acknowledge them as part of the nursing team, improve their learning, and ensure that they are well-briefed on the patients they care for. This is a recommendation that I will be making in my executive summary to Northside Hospital, and in any presentations there.

In terms of career ladders, it could be argued that the large scale loss of LPNs in hospital settings could hinder the development of career ladders, since they are an

obvious rung between CNA and RN, and the LPN license can be achieved with only one year of full-time education. However, the associate's route to the RN certification, while being less prestigious than the bachelor's degree, means that CNAs can graduate in only two years full-time equivalence, and there are conversion courses available to complete the baccalaureate at a later date if they choose. However, there is a policy issue that should be considered concerning the unaccredited cross-training of CNAs.

Because their cross-training lacks accreditation, CNAs are unable to take their skills to new jobs, or receive credit for them when they undertake further education and training. While it may be prohibitively expensive for independent, non-profit hospitals like Northside Hospital to institute accreditation for the cross-training they provide, 62% of community hospitals are part of a healthcare system (Health Forum LLC 2014), and there would be economies of scale in partnering with education providers to introduce accreditation and to ensure that cross-training credits will be accepted. This would benefit CNAs who are seeking further training both financially and in terms of time needed to complete their education. In addition, a more widespread provision and acceptance of enhanced accredited CNA certifications, such as the Level II acute care CNA certification from Oregon, or the Patient Care Technician certification (National Healthcareer Association N.d.; Oregon State Board of Nursing N.d.) would be useful in providing a more formal career ladder within the CNA occupation.

The findings on emotional labor raise questions about the recognition of emotional labor and affective care by hospital managers. Affective care is hard to quantify, and it is difficult to prove its therapeutic value in acute care settings. Patients value it, as shown by their gratitude and feedback concerning staff. But it is not a selling

point as it is in nursing homes. It seems likely that emotional labor slips below the radar in consideration of hospital work, but that it is expected, and CNAs may be selected for their warmth and empathy at the recruitment stage. Since this study only included CNAs as participants, these conclusions are one-sided, and could only be tested by looking at other aspects of the hospital institution, such as recruitment and management of CNAs.

Limitations of the Research

While it may be customary to talk about a small sample size as a limitation to most qualitative research, in the case of this study, it is a valid concern. This study breaks new ground, and conclusions must be tentative and a starting point for further research, given that there were only 21 participants. In addition, since the sample was largely self-selecting, it is impossible to gauge how representative it is of Northside Hospital, let alone of hospital CNAs in general. The lack of quantitative and demographic data about hospital CNAs also makes it difficult to place my sample in a broader context.

Another concern is how representative Northside Hospital is of U.S. hospitals. It shares its independent status with 38% of U.S. community hospitals and its non-profit status with 58% (Health Forum LLC 2014). However, it is a rarity in having Magnet status for nursing, since only 7% of hospitals share that (The Truth about Nursing 2012). In particular, the Magnet recognition makes it atypical of American hospitals and in the forefront of hospital nursing practice. While CNAs are not part of the Magnet recognition program, it is likely having a highly-credentialed nursing team has an impact on the CNAs as well. It may be that such hospitals would choose to employ more highly-educated CNAs, or CNAs would receive better supervision or informal education by RNs at the unit level. However, it may also be the case that having highly-qualified nurses has

a negative effect, in that nurses with BSNs may enforce the division of labor more strongly, and be unwilling to pitch in and perform menial tasks that are considered part of the CNA's work, something which CNAs complained about.

Another limitation of the research is the lack of observation data. Direct observation of interactions between CNAs and patients, and CNAs and RNs, would be very useful in supplementing the interview data. However, the difficulties of dealing with issues of patient privacy as encoded in the HIPPA regulations meant that it was impractical to include such observations.

While much of this study focuses on CNA care of patients, the relationship between the work of CNAs and RNs is also a major part of the research. By interviewing only CNAs I was unable to look at the other side of these relationships. Part of the decision to only interview CNAs was pragmatic, since including nurses and other staff would have made this a much larger project. However, there was an important methodological and theoretical rationale for exclusively interviewing CNAs. First, while there is a large literature on nursing, CNAs have not been studied in hospitals, so it was important to focus on the poorly-understood group. Second, by interviewing a group at the bottom of the hospital hierarchy, I was able to "read up the power structure" (Mohanty 1984; 2003), studying up in the organization to look at how the institutional and professional structures of hospital life impacted the work of CNAs from their point of view. Many CNAs felt that they had story that had not been told before, and felt validated by the experience of being listened to. However, a study of RNs that focused on the division of labor at the unit level, and the interaction with CNAs would have told a different part of the story, and would be useful work for the future.

Another limitation to the study was my own lack of experience in methods other than interviewing. It took a while to understand that any interactions in hospital, including recruitment meetings, were observational data and should be fully recorded.

Further Research

My current research is the first study to look in detail at the labor process of nursing assistants in hospital settings. A number of avenues for future research suggest themselves from this initial study.

Demographics and Quantitative Data

There is a shortage of demographic information about hospital-based CNAs. The largest survey of nursing assistants, the National Nursing Assistant Survey (Centers for Disease Control 2012), was a telephone-based survey conducted in 2004, but only sampled CNAs working in nursing homes. Yamada (2002) replicated an earlier analysis (Crown, Ahlburg and Macadam 1995) that used the Current Population Study (CPS) to compare the demographics of nursing aides working in hospitals, nursing homes and home health settings. This is the source of the information that hospital-based CNAs typically have more education than those in other settings, and other demographic comparisons. More detailed data specifically sampling hospital CNAs would be useful for researchers, and for workforce planning in hospitals.

Cross-Training of Nursing Assistants in the United States.

The issue of cross-training of CNAs is one area that would benefit from a more diverse study. In the initial research it was clear that cross-training at the research site was all unaccredited and in-house, meaning that it was non-transferrable to other hospitals. According to my informants, this is also the case in other hospitals. While there

are some pathways to advanced training for CNAs, it seems that these are not widely required in U.S. hospitals and, as a result, do not lead to enhanced pay and benefits. Initial research in this area could consist of a survey looking at the uptake of accredited advanced training paths, such as the Oregon CNA II certification, or the national Patient Care Technician certification. It would also examine the extent to which hospitals specifically target these certifications in their recruitment material, or promote them among their staff. The initial methodology could include questionnaires to certifying bodies, training providers and hospitals in a particular region of the United States, with follow-up interviews with key informants in these institutions. In the longer term, it could also include interviews with CNAs focusing on education, training and career paths.

Use of CNAs and LPNs in Different Kinds of Hospitals

While the use of LPNs in hospitals has been declining sharply for decades, data shows that there are some geographical areas and types of hospitals that use LPNs in greater numbers, for example, state hospitals and those in the South (Seago et al. 2004). A study of the three-way division of nursing labor would be useful in establishing whether the cross-training of CNAs is a response to the loss of LPNs in hospital settings, and how this different iteration of team nursing differs from the two-way split of the current study.

Affective Care, Emotion Work and Emotional Labor among CNAs

There are still many questions about the use of emotional labor and the valuation of affective care in hospitals. Since CNAs now perform the majority of the bedside care of patients, they are in the frontline of patient care, and the workers most likely to be using emotion work/emotional labor. As Strauss (1997) points out, bedside nursing often

involves performing tasks that patients are uncomfortable with, or even feel shame about, and the comfort work of CNAs involves managing those emotions by reassuring patients. CNAs also have the time, while performing their routine patient care, to talk to patients and comfort them emotionally. Yet the job on paper looks like a series of instrumental tasks. The question remains about whether they are explicitly expected to perform emotional labor as a commodity of benefit to the hospital, or whether their emotion work simply makes their work easier or more pleasurable. Emotional labor in a situation where workers might expect to feel empathy, since they are dealing with sick people, is very different from situations where workers might have to suppress and recast their emotions to fit in with employer requirements, such as sales, debt collection or flight attending. On the other hand, having a CNA who is lacking in warmth and empathy is perceived negatively by patients, no matter how efficiently he or she performs her duties.

Further research in this area is needed, including research on how hospital managers and supervisors perceive affective care and emotional labor, and how this plays out in processes of recruitment. My preliminary thoughts are that emotional labor is undervalued and flies under the radar, but that CNAs who appear warm and empathetic may be preferred for employment, and then left to do their thing. If this is the case, then what is actually a skill, in terms of being something that the hospital requires, is being recast as an attitude or essential characteristic, something which is often seen in jobs that are as highly gendered as nursing assisting, and which is reflected in the poor compensation of such jobs.

The International Use of Unlicensed Assistive Personnel in Hospital Care

The use of auxiliaries in hospital nursing has been a cause of debate and concern

internationally. There has been discussion in many European countries concerning the use of nursing assistants alongside graduate nurses, role drift, caring as a core practice of nursing and similar (Benoit and Heitlinger 1998; Castledine 2004; Corbin 2008; Dahle 2003; Davies 1982; Daykin and Clarke 2000; Edwards 1997; Lee-Treweek 1997; Maben 2008; McKenna et al. 2007; Thomas 1994). As in the United States, this debate has been driven by nursing leaders and healthcare institutions, although in most European countries hospitals are public, rather than private, institutions. There has been little study of the labor process of nursing auxiliaries and of the division of labor between them and other grades of nurses. Nursing aides are part of the International Standard Classification of Occupations, 2008 revision, (International Labour Organization 2010) where they are classified as “health care assistants,” ISCO code 5321, a subset of “Personal Care Workers in Health Services”(World Health Organization 2010). This classification allows for international comparisons of the roles of assistants. This study would require a survey of hospital care in a number of European countries, looking at funding, organization and at the different grades and training levels of nursing staff, including unlicensed assistive personnel, followed by targeted fieldwork in a number of countries.

Reflections and Implications for My Own Research Practice

As in all research, I learned a number of lessons during this study that I can use to improve my future research methods and protocols.

Initially, I thought that approaching a hospital that had no IRB would make access easier, but ultimately I found that a hospital that was accustomed to research was more accessible, since there was a familiarity with research protocols and the processes were in place to approve research. I was also lucky in that one of the hospitals I approached was

immediately interested and made access much easier than I anticipated. In the end, rather than a gatekeeper, I found someone who was able to smooth my way and explain the institution as an insider. It is probable that working with an independent hospital also made the decision-making process easier, since there were fewer levels of administration. If I were to work with a hospital that was part of a chain in the future, I might expect to have a longer and more complex negotiation in order to gain access.

In terms of recruitment of participants, my method quickly evolved during the process. When I was offered the opportunity to visit each unit and talk to CNAs (and sometimes RNs as well) about the research, I quickly took it. The form of these meetings varied according to the Unit Manager, so sometimes the CNAs were presented to me in a corner of the unit, and other times I was fitted in to the handover meeting. I soon discovered that it was more effective to collect contact details of potential participants when I visited the units, rather than simply give out my contact details and hope that participants would contact me.

Putting myself into the shoes of the CNAs helped me to understand while this research was the most important thing in my life at the time, it was of minor relevance to CNAs, even if they were interested and willing. CNAs have busy lives, including shift work, but also often including study and family life. The Director of Nursing suggested that being interviewed at the hospital would suit CNAs better than my initial plan to interview participants outside their workplace. I was offered a discreet room in which to interview, in a place where confidentiality would not be compromised. This enabled me to interview many CNAs either before or at the end of their shift, which suited first and second shift workers, and even some who lived nearby and came to the hospital specially

to be interviewed. I offered everyone the option to be interviewed outside the hospital, but most people chose the hospital.

In addition, the method of contact with potential participants had to be varied. While some of the younger CNAs are comfortable with electronic media, many potential participants wanted to be contacted by telephone, and I often made multiple phone calls with little success. It is worth remembering, though, that multiple phone calls that do achieve the desired end- booking an interview- are not wasted, and it is impossible to determine whether effort is wasted until you decide to stop the phone calls! Emails were also difficult initially, since the amount of information which the IRB required me to send meant that the actual message about arranging interview times got lost in verbiage. This is not optimal for email contact, since most people expect emails to be concise. As a result, I set up a website with the information in FAQ (Frequently Asked Questions) format (see Appendix D) with a link from the email, and a link to a booking system. This was not particularly effective, but I did not set it up until late in the process. If I undertake a similar project, I will try this kind of system again from the beginning and see if it is more successful.

One lesson I learned during the process is that even with an interview-based method, any contact with the institution is an opportunity for observation and data collection. While I did make some notes during my recruitment visits, these focused on the recruitment process, rather than more general notes about each unit and what I observed there (although I did note some useful information, almost by accident). I could have got better data had I asked some questions about each unit and what their specialisms were, rather than depend on the CNAs to tell me at the interview stage. I

could also have made better notes on the look of each unit, and the kinds of staff interactions I saw while waiting to enter the meetings and say my piece.

In hindsight, I would have been better served if I had transcribed the interviews shortly after they were done. There were periods of intense interview activity, and I left most of the transcription until the end of the interviewing phase, which meant that I had less time to mull over the content, write memos and do the preliminary analysis.

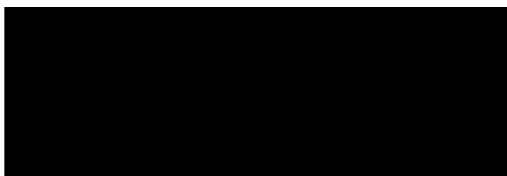
Since my Master's research was also interview-based, I was familiar and fairly skilled at interviewing, but there was the added complication of the abbreviations, equipment names and technical language that are a normal part of hospital life. In some cases I asked for clarification during the interview, but there was also a great use of internet search engines while transcribing to find out correct spellings and meanings. It can be hard to break the thread of a narrative to ask for this kind of clarification, but a quick paper notation during the interview and follow-up questions at the end might have been effective.

Concluding Remarks

While CNAs are generally perceived as at the bottom of the hospital hierarchy, there to do nothing but the dirty work, my experience of them is that they have a strong sense of purpose and responsibility, are engaged and intelligent, and feel that their work is important. Many of the skills that they use in their work are overlooked. This includes the soft skills that allow them to interact and empathize with a wide variety of patients. In addition, since they have the most regular and longest contact with patients they are gatekeepers for nursing and other staff, and effective gatekeeping requires the knowledge to know when to call in reinforcements, and when they can meet the patient's immediate

needs. Some have special duties due to their cross-training, but there are also informal tasks that they are called upon to do, such as the interpreting that some of the Latina and other CNAs mentioned. While there has been some debate in the nursing literature about whether the loss of RNs at the bedside and their replacement by unqualified assistants is detrimental to patient health, there seems to be no rush to return to primary nursing. The pressure to increase the credentialing of RNs and the push for their acceptance as full professionals means that they are unlikely to want to take back the dirty work that is part of nursing. Furthermore, this is unlikely to appeal to hospital managers; RNs earn three times as much as CNAs, so the cost of doing this would be phenomenal. I think that CNAs in hospitals are here to stay, and their role is becoming more complex through cross-training and the loss of LPNs in hospitals. Having a clearer understanding of their work and their lives would be beneficial in making sure that they are recognized, that the problems of retention that are seen in nursing homes are not found in hospitals, and that their role in the increasingly technological and impersonal hospital setting is better understood. This study is the first step in that undertaking.

APPENDIX A
INFORMED CONSENT FORM



Preparing people to lead extraordinary lives

Interview Consent Form

Who Cares? The Role of Nursing Assistants in the Labor Process of Hospital Nursing

You are being asked to participate in a dissertation research project on nursing assistants working in hospitals being conducted by Grace Scrimgeour, a graduate student at Loyola University Chicago in the Department of Sociology. The purpose of this research is to learn more about the role of nursing assistants in the nursing team, how they view their work and career, and how they came to work as nursing assistants. The researcher will be interviewing about 30 nursing assistants in total.

If you agree to participate, you will be asked questions on your life and work experiences, including your daily work routines. You will not be asked about particular patients' medical issues or anything that would breach HIPPA regulations. I am interested in the general kinds of interactions you have with patients and staff, how you view your role in the hospital, what you enjoy about the work and what difficulties there are. I will also ask you some basic information about your family, education, previous work experiences and career aspirations.

The interview will take approximately 90 minutes, and will be conducted outside work time at a location convenient to you. While the hospital has approved the project, they will not know if you have participated, to protect your anonymity. The interview will be recorded and the audio file will be kept on a password-protected computer, along with the transcript. To ensure your confidentiality all consent forms will be kept in a separate locked storage cabinet, to which only the researcher has access. Your name and identity will not be used in the work; pseudonyms will be used in all writings, publications or presentations to further protect your confidentiality.

The interview is voluntary and you may choose to refuse to answer any questions or withdraw from participation at any time without penalty. You are free to ask questions concerning the research or research procedures at any time during, or after the interview. You will be provided with a copy of this consent form.

The study is designed to learn about the experiences and views of people like you in general and not to benefit you personally. If you agree to participate, you will be adding valuable information that will contribute to knowledge about nursing assistants in hospitals. In nominal appreciation of your participation, you will be given a gift card in the amount of \$20, which you may keep even if you end the interview early.

If you have any questions about this study, you may contact the researcher, Grace Scrimgeour at CNASTudy@gmail.com or (773) 801-5865, or the researcher's faculty advisor, Dr. Anne Figert of Loyola University at (773) 508-3431, or [REDACTED], Director, Educational Programming, [REDACTED]

If you have questions about your rights as a research participant, please contact Loyola Assistant Director of Research Compliance at (773) 508-2689, or [REDACTED], [REDACTED] Institutional Review Board Co-Chairman, at [REDACTED] or [REDACTED] Legal Counsel, at [REDACTED]

Signature of Investigator..... Date

Signature of Interviewee Date.....

Grace Scrimgeour, MA
Department of Sociology
1032 W. Sheridan Rd.,
Chicago, IL 60660

Participant Number:

APPENDIX B

FLYER DISPLAYED IN UNITS AT NORTHSIDE HOSPITAL

Nursing Assistants Study



Preparing people to lead extraordinary lives

Do you work as a nursing assistant in this hospital?

Would you like to help improve other people's understanding of the work you do?

Are you at least 18 years old?

We want to hear from you!

Grace Scrimgeour, a doctoral student in the Department of Sociology at Loyola University Chicago, is conducting a dissertation study on the work and lives of nursing assistants who work in hospitals.

You will be asked to participate in a confidential ninety-minute interview at a time and place that is convenient for you. You will receive a \$20 gift card for your time.

If you have any questions, please contact the researcher, Grace Scrimgeour, at Loyola University Chicago

Website: homepages.luc.edu/~gscrimg/cna.html

Email: cnastudy@gmail.com or Phone: (773) 801-6865

or her faculty advisor, Dr. Anne Figert at afigert@luc.edu or (773) 508-3431, or

[REDACTED], Director, Educational Programming, [REDACTED]

APPENDIX C

BUSINESS CARDS HANDED TO POTENTIAL PARTICIPANTS AND LEFT AT
UNIT NURSING STATIONS



Preparing people to lead extraordinary lives

Grace Scrimgeour

Doctoral Candidate

Department of Sociology

Lake Shore Campus
1032 W. Sheridan Rd
Chicago, IL, 60660

(773) 865 7693
gscrimg@luc.edu

Are you a nursing assistant in this hospital?

Would you be willing to be interviewed about your work?

I am recruiting participants for a study of the role of
nursing assistants in hospitals.

Call (773) 801-6865 or email cnastudy@gmail.com
for more information or to participate.

APPENDIX D
WEB PAGE WITH FAQ

[Home](#)
[CNA Study](#)
[CV](#)
[Blog](#)

CNA STUDY- Frequently Asked Questions

What is this about?

I am a PhD candidate in sociology at Loyola University Chicago and I am looking for people who are CNAs at your hospital to interview for my study of nursing assistants who work in hospitals, called "Who Cares? The Role of Nursing Assistants in the Labor Process of Hospital Nursing"

The project has the approval of the hospital, but all interviews will be confidential and anonymous- the hospital will not know if you have been interviewed, and interviews will take place outside of work hours. The interview will take no more than 90 minutes, and you can choose a place that is convenient for you.

I can't pay for your time, but I am offering a Target gift card for \$20 in thanks for your participation.

What will the interview be like?

I will ask you questions about your daily routine at work, your role within the nursing team, your family, previous work experience, career aspirations, education and some basic demographic information. The goal is to learn more about the role of nursing assistants in hospitals and to help improve other people's understanding of your work.

Your participation is entirely voluntary and you do not have to answer any questions that you do not feel comfortable with. You will be asked to sign a consent form that explains how the information will be used and what your rights are as a participant.

What happens to the information I give you?

I will record the interview using a digital recorder, and transcribe your words, changing your name. I will then analyze what you say, along with all the other interviews and use the information in my PhD dissertation and for academic presentations and articles, which may be published. I may quote you in some work, but your name will be changed, and I will not publish any personally identifiable information about you.

How can I arrange an interview?

If you don't mind being interviewed in the hospital, I have a regular room booking in a quiet corner away from management offices, on Tuesday and Thursday afternoons and evenings at 1.30pm, 3.30pm, 5.30pm and 7.30pm, which means I can interview most people before or after their shift. If you want to schedule at one of these times, please click the **Book Now** symbol at the bottom of this page. You can check for available slots and book directly, or just email me at CNAstudy@gmail.com with your preferences, or call me at (773) 801-5865.

If you prefer to be interviewed away from the hospital, I can interview you at Loyola University Lake Shore campus ([Coffey Hall, Room 418](#)) or at a quiet coffee shop or any quiet public space that is convenient to you. My time is quite flexible, so let me know when you would be free.

I want more information

You can email me or call me with any questions. You can also talk to the chair of this research project, Dr. Anne Figert, at (773) 508 3431. If you have any questions about your rights as a research participant, you may call Loyola University's Assistant Director of Research Compliance at (773) 508-2689.



book now

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APPENDIX E

ORIGINAL SCHEDULE OF INTERVIEW QUESTIONS

Who Cares? The Role of Nursing Assistants in the Labor Process of Hospital Nursing

Schedule of Questions

Labor Process and care

Can you take me through your last shift- tell me what you did, who you talked to? Don't give me patient names or details, just talk about what you did and said, and your interactions.

Was this a good shift? If so, can you tell me about a recent shift that was harder? (or easier?).

Tell me about the last time you first saw a new patient. How did you introduce yourself? How did you break the ice? What did you do the first time you saw a patient on your last shift?

What have you done that is different from the RNs and other hospital staff? Give me some examples. What do you think your unique contribution has been? Give me some examples of that.

Can you give an example of a time when you gave what you consider to be good care? I'm not talking about the outcome, necessarily, but about how you felt about the care you were giving, and how the patient responded to you. What about an example when you weren't happy with the care you were giving?

Think of an actual event. When a patient rang the bell and you responded, how did you decide whether you could deal with the situation yourself, or whether you had to call in someone else?

Can you give me some specific examples of things you enjoy most about the job, things that give you the greatest satisfaction? Can you give me some specific examples of things you don't enjoy about the work? Can you tell me about some incidents that you found frustrating in your work?

In your experience, what have patients appreciated most about your work? How do you know they appreciate it?

Give me some examples of what unit managers emphasize as the most important parts of the job? How do they let you know that? Are they different from the things you think are most important?

What have you done when you noticed something not right with the patient, e.g. you are washing them and you notice skin problems, or if they seem rather unresponsive? Tell me about this time. Did you chart this, tell the RN, do something else? Did other staff listen and act on information you gave them?

Tell me about a time when you got upset at work? Where did you go, what did you do, who did you talk to?

Have you had any opportunities to meet and network with other nursing assistants, either inside or outside this hospital? If so, can you tell me about an event you attended? Are you a member of any nursing assistant organizations or unions?

Do you have any control over your shift patterns, or are they allocated to you?

Do you have any opportunity to do paid overtime, or take any extra shifts?

Have you worked as a CNA in any other kinds of places, like nursing homes for example? Give me some examples of how the job was different there.

Education, previous jobs and job aspirations

Can you tell me about your education?

Can you tell me about any previous jobs you did before you became a CNA? What did you like and dislike about them?

How did you decide to become a CNA? What prompted you? Where did you go for training, and how did you get this particular job?

Do you plan to stay as a CNA, or do you want to get a different job eventually? What will you need to get that job?

Do you have any other jobs at the moment?

Do you think there are opportunities here to get training and promotion? Does the hospital offer training or support CNAs in getting training? If so, how?

(Ask, discreetly, if they have ever been on welfare, if it doesn't come up in interview)

Family and work-family balance

Can you tell me about your family and household? Do you live alone, who lives with you?

Do you have children? How many, ages.

What kind of housing do you live in? Apartment, house, condo, rented, owner-occupied?

Are you the sole or primary breadwinner for your household?

Does your income cover the necessary bills for your household?

Do your shifts fit in with any childcare or family care responsibilities?

Do you need childcare, either paid or unpaid, from other family members?

Tell me about a time when there were conflicts between work and home responsibilities, e.g., if a child gets sick?

How do you get all the work at home done? Do you have help?

What do you do to unwind or relax? (Do you have time to unwind or relax?).

Demographic questions not covered in main interview

Age, gender, marital/cohabitation status

Race-ethnicity, self-defined. Languages spoken.

APPENDIX F

REVISED SCHEDULE OF INTERVIEW QUESTIONS

Grace Scrimgeour- Nursing Assistants**Schedule of Questions*****Labor Process and care***

Can you give me your name? Are you part-time or full-time? Which unit do you work on? What does the unit specialize in?

Can you take me through your last shift- tell me what you did, who you talked to? Don't give me patient names or details, just talk about what you did and said, and your interactions.

Was this a good shift? If so, can you tell me about a recent shift that was harder? (or easier?).

Tell me about the last time you first saw a new patient. How did you introduce yourself? How did you break the ice? What did you do the first time you saw a patient on your last shift?

How many patients do you care for on average in a shift? How many other CNAs are there per shift? What is the full census for your unit?

How long do patients typically stay on your unit? Hours, days, weeks?

What have you done that is different from the RNs and other hospital staff? Give me some examples. What do you think your unique contribution has been? Give me some examples of that.

Can you give an example of a time when you gave what you consider to be good care? I'm not talking about the outcome, necessarily, but about how you felt about the care you were giving, and how the patient responded to you. What about an example when you weren't happy with the care you were giving?

Can you tell me what you do to make patients comfortable? What does that mean to you?

Think of an actual event. When a patient rang the call light and you responded, how did you decide whether you could deal with the situation yourself, or whether you had to call in someone else?

Can you give me some specific examples of things you enjoy most about the job, things that give you the greatest satisfaction? Can you give me some specific examples of things you don't enjoy about the work? Can you tell me about some incidents that you found frustrating in your work?

In your experience, what have patients appreciated most about your work? How do you know they appreciate it?

What about if patients are difficult, abusive or even violent? What strategies do you use to deal with those situations? Where did you learn those strategies?

What have you done when you noticed something not right with the patient, e.g. you are washing them and you notice skin problems, or if they seem rather unresponsive? Tell me about this time. Did you chart this, tell the RN, do something else? Did other staff listen and act on information you gave them ?

Give me some examples of what unit managers emphasize as the most important parts of the job? How do they let you know that? Are they different from the things you think are most important?

Tell me about a time when you got upset at work? Where did you go, what did you do, who did you talk to?

Do you have any control over your shift patterns, or are they allocated to you?

Do you have any opportunity to do paid overtime, or take any extra shifts?

Have you worked as a CNA in any other kinds of places, like nursing homes for example? Give me some examples of how the job was different there.

Do you consider what you do as nursing? Is that because of what you do personally, or do you think what CNAs do generally is (or is not) nursing? What is nursing, in your view?

Education, previous jobs and job aspirations

Can you tell me about your education? Are you currently a student, or do you plan to be in the near future?

Can you tell me about any previous jobs you did before you became a CNA? What did you like and dislike about them?

How did you decide to become a CNA? What prompted you? Where did you go for training, and what did the training cover? how did you get this particular job?

Do you plan to stay as a CNA, or do you want to get a different job eventually? What will you need to get that job?

Do you have any other jobs at the moment?

Do you think there are opportunities here to get training and promotion? Does the hospital offer training or support CNAs in getting training? If so, how?

Are you trained as a unit assistant (unit secretary)? Can you tell me about that training? Are you scheduled as a unit assistant OR a CNA, or are you expected to cover both jobs in a shift?

Have you had any other training specific to your unit?

Family and work-family balance

Can you tell me about your family and household? Do you live alone, who lives with you?

Do you have children? How many, ages.

What kind of housing do you live in? Apartment, house, condo, rented, owner-occupied?

Are you the sole or primary breadwinner for your household?

Does your income cover the necessary bills for your household?

Do your shifts fit in with any childcare or family care responsibilities?

Do you need childcare, either paid or unpaid, from other family members?

Tell me about a time when there were conflicts between work and home responsibilities, e.g., if a child gets sick?

How do you get all the work at home done? Do you have help?

What do you do to unwind or relax? (Do you have time to unwind or relax?).

Demographic questions not covered in main interview

Age, gender, marital/cohabitation status

Race-ethnicity, self-defined. Languages spoken

[If they are bilingual] Do you ever find yourself interpreting for patients who speak your language?

Final Questions

Is there anything that you thought I'd ask you about that I didn't?

Is there anything else you think I should know about your work that we haven't covered?

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VITA

Grace Scrimgeour graduated from New Hall/Murray Edwards College, Cambridge University in 1983 with a B.A. (Hons) in Archaeology. She was awarded a Master of Arts from Cambridge University in 2011. After working as a field Archaeologist for 5 years, she changed to a career in social and community work in the voluntary sector. She worked for 4 years managing resettlement houses for homeless people, then for 8 years managing a welfare and workers' rights center. Before moving to the United States she worked at Ruskin College, Oxford, on a pilot project sponsored by the British Government, designing and teaching courses for people in grassroots community groups, focusing on development and capacity building.

From 2003 to 2013, Grace Scrimgeour attended Graduate School at Loyola University Chicago, where she received a number of honors. She was a Graduate Fellow at the Center for Urban Research and Learning from January 2004 to December 2006, and a Women's Studies Graduate Scholar in 2004 and 2005. In 2004 she was inducted into Phi Beta Delta, the Honors Society for International Scholarship. In 2005 she completed a Master of Arts degree in Sociology with a thesis entitled "*Women Without Children: Making Decisions about Mothering in the Life Courses of Women.*" Grace Scrimgeour was awarded a Pre-Doctoral Teaching Fellowship in 2008 and an Advanced Doctoral Fellowship in 2009. She completed Comprehensive Examinations in Sociology of Work, Occupations and Professions in the United States (2009) and

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Grace Scrimgeour has taught undergraduate classes at Loyola University Chicago since 2006, specializing in Sociology of Gender, Family and Social Problems as well as an urban class focusing on Chicago. Her research interests include the sociology of work and occupations, healthcare occupations, sociology of gender and social inequality